

Understanding Young Children in the Child Welfare System

Judge Cindy Lederman
Joy D. Osofsky, Ph.D.

Through the Eyes of a Child, XI
Annual Judicial Officers' Conference
Bend, Oregon
August 12, 2008



Young Child in Foster Care

Approximately one out of four
maltreated children are under
the age of four.



(Silver, 2000)

In 2006,
91,278 infants less than one year old
(23.2 % per 1000 population)
experienced substantiated nonfatal
maltreatment , including 29,881
(32.7 %) who were less than one
week old.

CDC, “Nonfatal Maltreatment of Infants”, MMWR,
57(13): 336-339, April 4, 2008

Neglect was the maltreatment category cited for 68.5% of the infants.

- 32.7% were aged less than one week
- 30.6% were less than 4 days old.

CDC, "Nonfatal Maltreatment of Infants", MMWR, 57(13): 336-339, April 4, 2008

Portrait of Young Children in Foster Care in U.S.

- More likely to be abused and neglected
- 79% of child fatalities occur under age 4
- Remain in placement longer (twice as long)
- 33% return to placement
- Lower rate of reunification
- Developmental delay is 4 to 5 times greater than children in general population
- More than half suffer from serious physical health problems

Physical Development

Involvement with CWS correlated with negative impact on physical development

- Shorter
- Smaller head circumference
- 59% either over/underweight – 3X normal population

* National Survey of Child and Adolescent Well-Being (NSCAW), CPS Sample Component, Wave 1 Data Analysis Report, April 2005

Prevalence Rates of Developmental Delay

■ FOSTER CARE

- Overall Delay: 60%
 - Language – 57%
 - Cognitive – 33%
 - Gross motor – 31%
 - Growth problems – 10%

■ GENERAL POPULATION

- Overall Delay:
 - 4% to 10%

Leslie, L.K. et al (2004) Journal of Developmental and Behavioral Pediatrics

Prevalence of Psychological and Psychiatric Problems

- FOSTER CARE

25% to 40%

under age 6 have significant behavioral problems, most displaying externalizing behaviors (aggression, anger)

- GENERAL POPULATION

3% to 6%

Leslie, L.K. et al. (2004). Journal of Developmental and Behavioral Pediatrics

Prevention and Intervention Must Start Early

- Aggressive, difficult behaviors seen in adolescents who present in juvenile court most often begin much earlier
- Abused and neglected infants are at very high risk for poor outcomes
- Early interventions can make a difference

Consequences of Developmental and Behavioral Problems

- Problems in both of these areas have been correlated with longer stays in care
- Reduced likelihood of reunification or adoption
- School related problems
- Adolescent at risk behaviors
- Placement changes

Trauma for infants and toddlers in foster care

- Separation from parents, usually sudden and traumatic
- Difficult experiences precipitating placement
- Frequently leads to temporary or permanent impairment in all areas of development

Adoption and Safe Families Act of 1997

Child's health and safety are paramount concerns in court proceedings

Emphasis on permanency and adoption

Stronger court role in monitoring the process

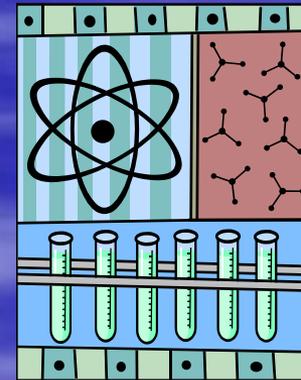
ASFA Regulations

- Federal ASFA regulations specifically hold States accountable for providing services to address the "safety, permanency and well-being of children and families." (45 C.F.R. Part 1357 §1355.33 b (2))
- States must ensure that:
 - "families have enhanced capacity to provide for their children's needs;
 - children receive appropriate services to meet their educational needs; and
 - children receive adequate services to meet their physical and mental health needs."** (45 C.F.R. Part 1357 §1355.34 b(1)(iii))

Juvenile Court Can Facilitate Healing

- Children in child welfare have been beaten, raped, ignored, and abandoned
- The juvenile court needs to help these maltreated babies – unfortunately, this may be the first time problems are seen
- Together, through partnerships, we must break the intergenerational cycle of abuse and neglect

OUR TOOLS: The law and science



Sometimes the Judge should
stop changing us from house to house.
~~They~~ They should listen to what the
Kids have to say ~~what~~ about what is in
their 

~~Foster~~ Foster
care

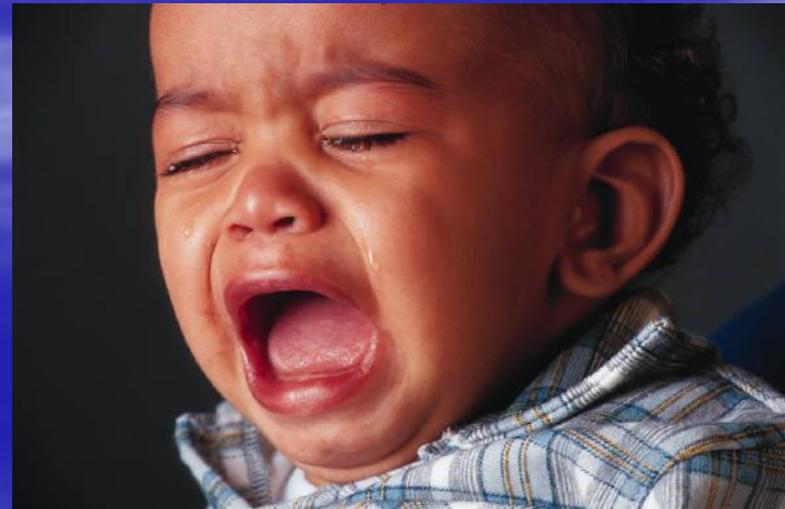


Ears

Lazaro age 12

**It is rarely the case that a
maltreated infant has no
symptomatology.**

Larrieu, 2002, Institute of Infant and Early Childhood Development,
Tulane University Medical Center



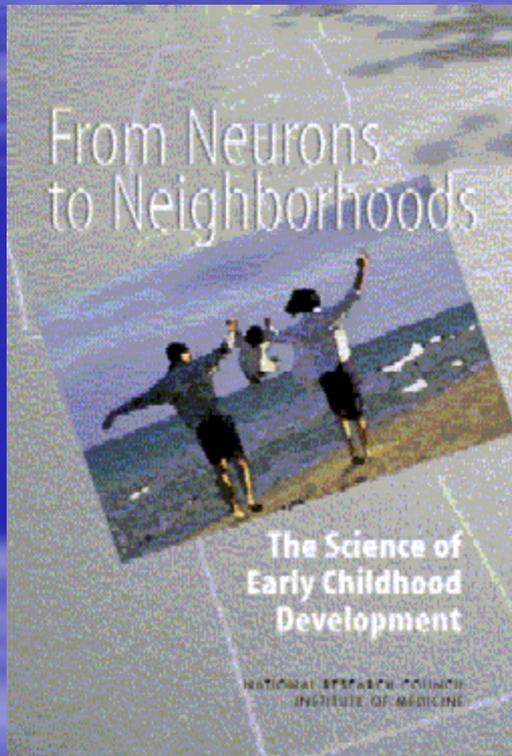
Consequences of Child Maltreatment

- Maltreatment places children at risk
 - **INFANCY & TODDLERHOOD (0-5)**
 - poor attachment
 - delayed developmental milestones
 - **SCHOOL AGE (6-12)**
 - aggressive behavior
 - social isolation
 - learning problems
 - **ADOLESCENCE (13-18)**
 - school failure and school dropout
 - delinquency and later criminal behavior

Research Findings: the Link Between Dependency and Delinquency

- **The Cycle of Violence** (research by Cathy Spatz Widom, Ph.D. funded by the National Institute of Justice)
 - Childhood abuse increased the odds of future delinquency and adult criminality by 40%
 - Being abused or neglected as a child increased the likelihood of
 - arrest as a juvenile by 53%
 - arrest as an adult by 38%
 - arrest for a violent crime by 38%
 - Intergenerational transmission: ***Violence begets violence and neglect begets violence.***

From Neurons to Neighborhoods: The Science of Early Childhood Development



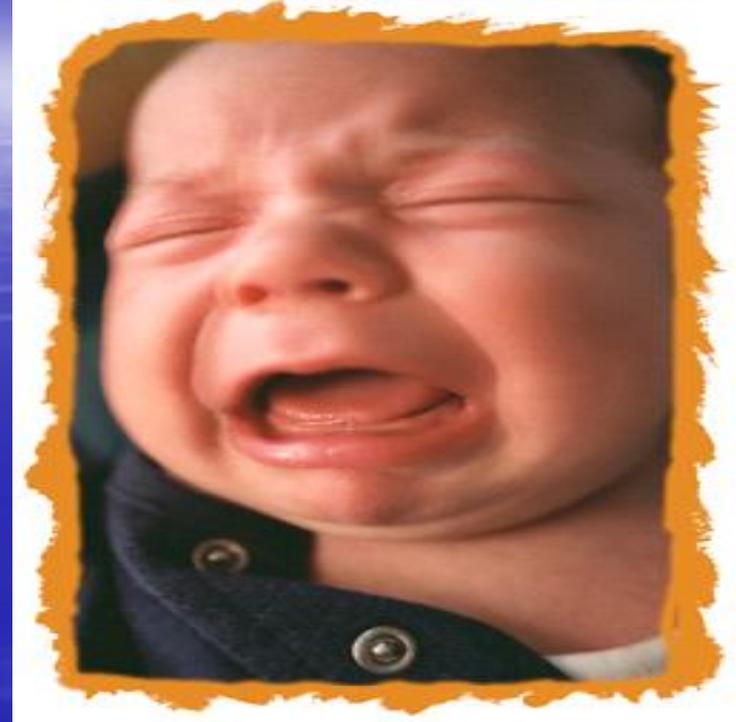
**Committee on Integrating
the Science of Early
Childhood Development**

**Board on Children, Youth, and Families
Institute of Medicine
National Research Council**

Core Concepts of Development

- **Early environments matter** and nurturing relationships are essential
- **Human relationships** and their effects are the building blocks of development.
- Effective interventions in early childhood by can alter development by **changing the balance between risk and protection**
- Well designed interventions **can** enhance the short term performance of children living in poverty
- **Both biology and experience matter** : nature and nurture.

Signs in the baby that emotional needs are not met



- Lack of eye contact
- Weight loss
- Lack of responsiveness
- Sensory processing problems
- Rejects being held or touched

Signs of emotional problems In toddlers/ preschoolers



- Very aggressive behavior
- Attentional problems and deficits
- Lack of attachment
- Sleep problems or disorders

Conditions of the caregivers that contribute to baby's emotional problems



- Drug addictions
- Untreated depression
- Domestic violence
- Parent's own past history and experiences
- Otherwise emotional unavailability

What
Grown-Ups
Understand
About **Child**
Development:

A National Benchmark Survey

Researched by DYG, Inc.

Comprehensive Report



CIVITAS
Center for Applied Research

BRIQ.

**ZERO
TO
THREE**

At what age do you think a child can experience real depression?

Six months or
younger



At what age do you think a baby can begin to sense whether his parent is depressed or angry and can be affected by his parent's mood?

One to three months



A 6 month old or younger child who witnesses violence, such as seeing her father often hit her mother, can suffer long term effects from the experience, because children that young have a long term memory

True

The Infant Health and Development Program

An 8 site clinical trial designed to evaluate the efficacy of comprehensive early intervention in reducing developmental and health problems in low birth weight, premature infants

- 985 infants
- 5 ½ pounds or less
- Gestational age of 37 weeks or less
- 3 year study

Random Assignment

- INTERVENTION GROUP

- Pediatric surveillance
- Home visits (weekly for first year, biweekly thereafter)
- Infant enrolled in Child Development Center
- Parent education meetings

- FOLLOW-UP GROUP

- Pediatric surveillance



Results

- The Intervention Group children showed a significant difference in cognitive development: **from 6 to 13 IQ points higher**
- The Intervention Group mothers reported significantly fewer child behavior problems
- The Intervention Group children did not have more health problems despite their participation in group care

The Chicago Child-Parent Center (CPC) Program

15 year longitudinal study of the
effects of early childhood
interventions on educational
achievement and juvenile arrest



Reynolds, Temple Robertson and Mann,
JAMA, May 9, 2001

Results

- Higher rate of high school completion (49.7% vs. 38.5%)
- More years of completed education (10.6 vs. 10.2)
- Lower rates of juvenile arrest (16.9% vs. 25.1%)
- Less violent arrests (9% vs. 15.3%)
- Fewer school dropouts (46.7% vs. 55%)

Prenatal and Infancy Home Visitation



Olds, et al. 1997, 1998, 2002, 2004

Elmira Home Visitation Program: the mother

- 79% fewer verified cases of child maltreatment
- 33% fewer subsequent births
- Longer intervals between births
- Less substance abuse
- 81% fewer arrests and convictions
- 30 fewer months on welfare

HOME VISITATION: the child (at 15 years)

- 60% decrease in running away
- 56% fewer arrests
- 81% fewer convictions and probation violations
- Fewer sex partners
- Reduced cigarette smoking
- Reduced alcohol consumption
- **50% decrease in delinquency through age 15**

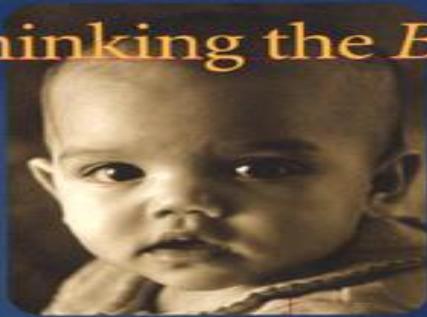


What Courts Can Do



Read the research:
Science can inform our
work

Rethinking the Brain



New Insights
into Early
Development

By Elissa Sheery



Ghosts from the Nursery

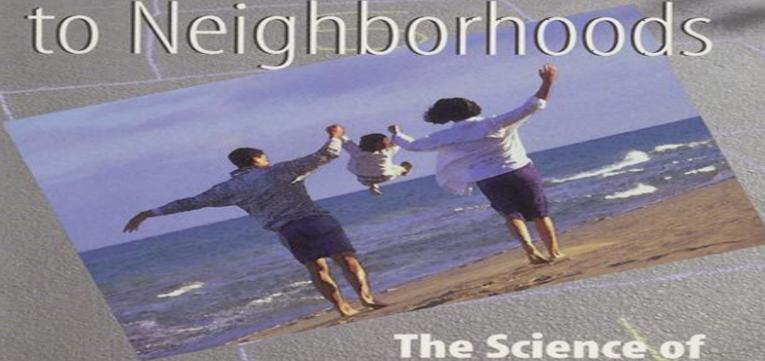


"This is an
eye-opening
book."
MARIAN WRIGHT EDELMAN

Tracing the Roots of Violence

Robin Karr-Morse and Meredith S. Wiley
Introduction by Dr. T. Berry Brazelton

From Neurons to Neighborhoods



The Science of Early Childhood Development

NATIONAL RESEARCH COUNCIL
INSTITUTE OF MEDICINE

A Good Beginning

Sending America's Children to School
With the Social and Emotional Competence
They Need to Succeed



THE CHILD MENTAL HEALTH
FOUNDATIONS and AGENCIES NETWORK

Make the First Placement the Last Placement

- Placement in a foster-to-adopt home in case reunification efforts not successful
- Adoption quality home studies on all potential placements including relatives

Separations occurring between 6 months and 3 years of age, especially if prompted by family discord and disruption, are more likely to result in subsequent emotional disturbances than earlier separations if followed by good quality of care .

American Academy of Pediatrics, 2000

Emotional and cognitive
disruptions in early lives of
children have the potential to
impair brain development.

Perry, Pollard, Blakely, Baker, Domenico, 1995

PART C, IDEA

Make sure all babies under the age of 3 are referred for a **Part C** screening pursuant to the **Individuals with Disabilities Act (IDEA)**

20 USC Section 1431 (2000)

Part C

Individuals with Disabilities Education Act

- Multidisciplinary evaluation for children age 3 and younger
- When established conditions have a high probability of resulting in developmental disabilities or delays
- CAPTA expanded entitlement to all maltreated babies
- No cost to family

Part C Provides a Rich Array of Services

Assistive technology devices and services

Audiology

Family training, counseling, home visits and parent support groups

Respite care

Medical services only for diagnostic or evaluation purposes

Nursing services

Nutrition services

Occupational therapy

Physical therapy

Psychological services

Service Coordination

Social Work services

Special instruction

Speech-language pathology

Vision services

Health services

Transportation



Refer pregnant women and new mothers to Healthy Start or Enhanced Healthy Start home visitation program



BRING BABIES INTO COURT



Make Appropriate Child Care Referrals:

EARLY HEAD START HEAD START

In Miami there are 1300 day care centers and only 382 are accredited. This is a consistent problem across the country.



Early Head Start Research

- Higher scores for language development
- Higher Bayley (developmental) scores
- Positive parenting outcomes
- Fewer “at risk” scores
- Fewer subsequent births
- Positive father-child interactions



DHHS, June 2002

Visitation Issues



When is Visitation **not** in the Best Interest of the Child ?

- Balancing the right of the parent to visitation versus harm to the child
- What if termination of parental rights case plan has been filed
- Parent is mentally ill or chronic substance abuser
- Visitation after severe abuse and/or neglect

Implement Developmentally Appropriate Visitation Practices

- Predictor of reunification is frequency of visits
- Infants and toddlers need frequent visitation to enhance attachment with parents
- Visits should occur:
 - as often as possible
 - for a long enough period of time
 - in a comfortable and safe setting

Refer for Infant/Child-Parent Psychotherapy

Goals of Child-Parent Psychotherapy

- The infant was harmed in the relationship and must be “healed” in the relationship
- Encourage return to normal development
- Help with engagement in present activities and future goals
- Restore trust and reciprocity in relationships
- Place a traumatic experience in perspective

Refer to Quality Parenting
Programs

BAD PARENTING?



Parenting Programs: What They Should Include

- Evidence based
- Pre test and post test
- Measured observations of parent with child at least twice during program
- Uniform detailed reports provided to the court with testing and observational scale included
- **No more “Certificates of Completion”**

Build Collaborative Partnerships for Children



There is no quick fix.



WEBSITES

- WWW.MIAMISAFESTARTINITIATIVE.ORG
- WWW.FUTUREUNLIMITED.ORG
- WWW.ZEROTOTHREE.ORG

Technical Assistance Brief

QUESTIONS EVERY JUDGE AND LAWYER SHOULD ASK ABOUT INFANTS AND TODDLERS IN THE CHILD WELFARE SYSTEM

By

Joy Osofsky, Ph.D., Candice Maze, J.D.,
Judge Cindy Lederman,
Justice Martha Grace, and Sheryl Dicker, J.D.



NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES

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QUESTIONS EVERY JUDGE AND LAWYER SHOULD ASK ABOUT INFANTS AND TODDLERS IN THE CHILD WELFARE SYSTEM

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NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES

INTRODUCTION¹

Increasing numbers of infants and young children with complicated and serious physical, mental health, and developmental problems are being placed in foster care.² The following checklists have been developed for use by judges, attorneys, child advocates, and other child welfare professionals in meeting the wide range of health care needs of this growing population.

PHYSICAL HEALTH

Has the child received a comprehensive health assessment since entering foster care?

Because children are likely to enter foster care as a result of abuse, neglect, homelessness, poverty, parental substance abuse, or mental illness, all foster children should receive a comprehensive physical examination shortly after placement that addresses all aspects of the child's health. Under the Early and Periodic Screening, Diagnosis, and Treatment provisions of federal Medicaid law³, foster children should receive a comprehensive assessment that can establish a baseline for a child's health status, evaluate whether the child has received necessary immunizations, and identify the need for further screening, treatment, and referral to specialists.⁴ A pediatrician or family practice physician knowledgeable about the health care problems of foster children should perform the examination.⁵

Ensuring the healthy development of foster children requires that they receive quality medical care. Such care should be comprehensive, coordinated, continuous, and family-supported. One person should be identified who will oversee the child's care across the various agencies and systems, including early childhood services, early intervention services, education, and medical and mental health. Family-supportive care requires sharing the child's health information with the child's caregivers and providing

caregivers with education and training programs in order to meet the needs of their foster child.

Are the child's immunizations complete and up-to-date for his or her age?

Complete, up-to-date immunizations provide the best defense against many childhood diseases that can cause devastating effects. Immunization status is an important measure of vulnerability to childhood illness and can reveal whether the child has had access to basic health care. Incomplete or delayed immunization suggests that the child is not receiving adequate medical care and is not regularly followed by a provider familiar with the child's health needs. A child should have a "well-baby" examination by two to four weeks of age. Immunizations are recommended at two, four, six, and 12 months of age. A child should have at least three visits to a pediatrician or family practice physician during the second year of life with basic immunizations completed by two years of age.⁶

Has the child received a hearing and vision screen?

Undetected hearing loss during infancy and early childhood interferes with the development of speech and language skills and can have deleterious effects on overall development, especially learning. Hearing loss during early childhood can result from childhood diseases, significant head trauma, environmental factors such as excessive noise exposure, and insufficient attention paid to health problems that may affect hearing. Studies reveal that 70 percent of children with hearing impairments are initially referred for assessment by their parents.⁷ Because foster care children often lack a consistent caregiver who can observe their development and note areas of concern, they should receive ongoing evaluations of hearing, speech, and language development.

Vision screening is an essential part of preventative health care for children. Problems with vision are

¹ Several of the questions follow the format of and contain excerpts from the "Checklists for Healthy Development of Foster Children," *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals*. New York State Permanent Judicial Commission on Justice for Children, 1999. Excerpted with permission.

² American Academy of Pediatrics, Developmental issues for young children in foster care. *Pediatrics*, Vol.106, No. 5, pp.1145-1150. November 2000. American Academy of Pediatrics, Health care of young children in foster care. *Pediatrics*, Vol.109, No.3 pp. 536-541. March 2002.

³ 42 U.S.C. Section 1396(a)(10) and (43)(2000); 42 U.S.C. Section 1396d(a)(4)(B)(2000) and 1396(r).

⁴ 42 U.S.C. Section 1396(a)(10)(2000); 42 U.S.C. Section 1396d(a)(4)(B)(2000).

⁵ *Supra* note 1.

⁶ American Academy of Pediatrics, Immunizations and your child. *American Academy of Pediatrics website*, June 27, 2002.

⁷ NIH Consensus Statement, Early identification of hearing impairment in infants and young children. Online 1993 March 1-3 [cited October 8, 2002]; 11 (1):1-24.

the fourth most common disability among children in the United States and the leading cause of impaired conditions in childhood.⁸ Early detection and treatment increase the likelihood that a child's vision will develop normally, and, if necessary, the child will receive corrective devices.

Has the child been screened for lead exposure?

Children who are young, low-income, and have poor access to health care are vulnerable to the harmful effects of lead.⁹ Ingested or inhaled lead can damage a child's brain, kidneys, and blood-forming organs. Children who are lead-poisoned may have behavioral and developmental problems. According to the Centers for Disease Control and Prevention (CDC), however, lead poisoning is one of the most preventable pediatric health problems today. Screening is important to ensure that poisoned children are identified and treated and their environments remediated.

The CDC recommends lead-poisoning screening beginning at nine months of age for children living in communities with high-risk lead levels. The CDC also recommends targeted screening based on risk assessment during pediatric visits for all other children.

Has the child received regular dental services?

Preventative dentistry means more than a beautiful smile for a child. Children with healthy mouths derive more nutrition from the food they eat, learn to speak more easily, and have a better chance of achieving good health. Every year, thousands of children between one to four years old suffer from extensive tooth decay caused by sugary liquids – especially bottles given during the night. Children living below the poverty level have twice the rate of tooth decay as children from higher income levels.¹⁰ Furthermore, poorer children's disease is less likely to be treated.

Early dental care also prevents decay in primary ("baby") teeth which is currently at epidemic proportions in some U.S. populations and is

prevalent among foster children.¹¹ The American Academy of Pediatric Dentistry recommends that before the age of one year, a child's basic dental care be addressed during routine "well-baby" visits with a primary care provider, with referral to a dentist if necessary. For children older than one year, the Academy recommends a check-up at least twice a year with a dental professional.

Has the child been screened for communicable diseases?

The circumstances associated with the necessity for placement in foster care – such as prenatal drug exposure, poverty, parental substance abuse, poor housing conditions, and inadequate access to health care – can increase a child's risk of exposure to communicable diseases such as HIV/AIDS, congenital syphilis, hepatitis, and tuberculosis.

A General Accounting Study found that 78 percent of foster children were at high-risk for HIV, but only nine percent had been tested for the virus.¹² Early identification of HIV is critical to support the lives of infected children and to ensure that they receive modified immunizations. Modified immunizations are necessary to prevent adverse reactions to the vaccines while still providing protection against infectious diseases such as measles and chicken pox. The American Academy of Pediatrics recommends that all prenatally HIV-exposed infants be tested for HIV at birth, at one to two months of age, and again at four months. If the tests are negative, the child should be re-tested at 12 months of age or older to document the disappearance of the HIV antibody.

Does the child have a "medical home" where he or she can receive coordinated, comprehensive, continuous health care?

All children in foster care should have a "medical home," a single-point-of-contact practitioner knowledgeable about children in foster care who oversees their primary care and periodic

⁸ American Academy of Pediatrics, Developmental surveillance and screening of infants and young children. *Pediatrics* Vol. 108, No. 1, pp.192-196. July 2001.

⁹ American Academy of Pediatrics, Screening for elevated blood lead levels (RE9815). *Pediatrics* Vol. 101, No. 6, pp. 1072-1078. June 1998.

¹⁰ Testimony of Ed Martinez, Chief Executive Officer San Ysidro Health Center, San Diego, CA to the Senate Subcommittee on Public Health, in support of Senate Bill 1626. June 25, 2002.

¹¹ American Academy of Pediatrics, Early childhood caries reaches epidemic proportions (Press Release). February 1997.

¹² General Accounting Office, "Foster Care: Health Needs of Young Children Are Unknown and Unmet." GAO/Health, Education and Human Services Division, pp. 95-114. May 1995.

reassessments of physical, developmental, and emotional health, and who can make this information available as needed.

DEVELOPMENTAL HEALTH

Has the child received a developmental evaluation by a provider with experience in child development?

Young foster children often exhibit substantial delays in cognition, language, and behavior. In fact, one half of the children in foster care show developmental delay that is approximately four to five times the rate of delay found in children in the general population.¹³ Early evaluation can identify developmental problems and can help caregivers better understand and address the child's needs.

Developmental evaluations provide young children who have identified delays with access to two federal entitlement programs:

- The Early Intervention Program for children under the age of three years, also known as Part C of the IDEA [20 U.S.C. Section 1431 (2000)], and
- The Preschool Special Education Grants Program for children with disabilities between the ages of three to five [20 U.S.C. Section 1419 (a) (2000)].¹⁴

Are the child and his or her family receiving the necessary early intervention services, e.g., speech therapy, occupational therapy, educational interventions, family support?

Finding help for young children may prevent further developmental delays and may also improve the quality of family life. Substantial evidence indicates that early intervention is most effective during the first three years of life, when the brain is establishing the foundations for all developmental, social, and cognitive domains. "The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes."¹⁵ Children with

developmental delays frequently perform more poorly in school, have difficulty understanding and expressing language, misunderstand social cues, and show poor judgment.

Early intervention provides an array of services including hearing and vision screening, occupational, speech and physical therapy, and special instruction for the child, as well as family support services to enable parents to enhance their child's development. Such services can help children benefit from a more successful and satisfying educational experience, including improved peer relationships.¹⁶ Foster children can be referred for early intervention and special education services by parents, health care workers, or social service workers. Early intervention services are an entitlement for all children from birth to three years and their families as part of Part C, IDEA. Both biological and foster families can receive Early Intervention Family Support Services to enhance a child's development.

MENTAL HEALTH

Has the child received a mental health screening, assessment, or evaluation?

Children enter foster care with adverse life experiences: family violence, neglect, exposure to parental substance abuse or serious mental illness, homelessness, or chronic poverty. Once children are placed in foster care, they must cope with the separation and loss of their family members and the uncertainty of out-of-home care. The cumulative effects of these experiences can create emotional issues that warrant an initial screening, and, sometimes, an assessment or evaluation by a mental health professional. Compared with children from the same socioeconomic background, children in the child welfare system have much higher rates of serious emotional and behavioral problems.¹⁷ It is important to both evaluate them and offer counseling and treatment services when needed so that early difficulties are addressed and later problems are prevented.

¹³ Dicker, S. and Gordon, E., Connecting healthy development and permanency: A pivotal role for child welfare professionals. *Permanency Planning Today*, Vol. 1, No. 1, pp. 12-15. 2000.

¹⁴ Website: <http://www.nectac.org/default.asp>.

¹⁵ Shonkoff, J. P. and Phillips, D. A., From Neurons to Neighborhoods: Committee on Integrating the Science of Early Childhood Development. National Academy Press, Washington, D.C. 2000.

¹⁶ American Speech-Language-Hearing Association, Frequently asked questions: Helping children with communication disorders in the schools – speaking, listening, reading, and writing. *American Speech-Language-Hearing Association website*, July 1, 2002.

¹⁷ Halfon, N., Berkowitz, G., and Klee, L., Development of an integrated case management program for vulnerable children. *Child Welfare*, Vol. 72, No. 4, pp. 379-396. 1993.

Children exhibiting certain behaviors may also signal a need for a mental health assessment and neurological and educational evaluations. Many of the symptoms associated with juvenile emotional and behavioral health problems can be alleviated if addressed early. The American Academy of Child and Adolescent Psychiatry recommends assessments for infants who exhibit fussiness, feeding and sleeping problems, and failure to thrive.¹⁸ For toddlers, the Academy recommends assessments for children exhibiting aggressive, defiant, impulsive, and hyperactive behaviors, withdrawal, extreme sadness, and sleep and eating disorders.¹⁹

Is the child receiving necessary infant mental health services?

The incidence of emotional, behavioral, and developmental problems among children in foster care is three to six times greater than children in the general population.²⁰ Children with emotional and behavioral problems have a reduced likelihood of reunification or adoption.²¹ Children with externalizing disorders, e.g., aggression and acting out, have the lowest probability of exiting foster care.²² During infancy and early childhood, the foundations are laid for the development of trusting relationships, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control.²³

To promote and facilitate permanency, children identified with mental health problems should receive care from a mental health professional who can develop a treatment plan to strengthen the child's emotional and behavioral well-being with caregivers. Services may include clinical intervention, home visiting, early care and education, early intervention services, and caregiver support for young children.

EDUCATIONAL/CHILDCARE SETTING

Is the child enrolled in a high-quality early childhood program?

Children cannot learn unless they are healthy and safe. Children learn best in high-quality settings when they have stable relationships with highly skilled teachers.²⁴ Such programs nurture children, protect their health and safety, and help ensure that they are ready for school. Early childhood programs also provide much-needed support for caregivers. Considerable research has indicated that early education has a positive impact on school and life achievement. Children who participate in early childhood programs have higher rates of high school completion, lower rates of juvenile arrest, fewer violent arrests, and lower rates of dropping out of school.²⁵ Many foster children are eligible for early childhood programs such as Head Start, Early Head Start, and publicly funded pre-kindergarten programs for four-year-olds.

Is the early childhood program knowledgeable about the needs of children in the child welfare system?

Most children are placed in foster care because of abuse or neglect occurring within the context of parental substance abuse, extreme poverty, mental illness, homelessness, or physical disease, e.g., AIDS. As a result, a disproportionate number of children placed in foster care come from the segment of the population with the fewest psychosocial and financial resources and from families that have few personal and extended sources of support.²⁶ For all of these reasons, it is very important that these children's child care staff and teachers be well trained and qualified.

¹⁸ American Academy of Child and Adolescent Psychiatry, Practice parameters for the psychiatric assessment of infants and toddlers. *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 36, (10 suppl.). 1997.

¹⁹ *Ibid.*

²⁰ Marsenich, L., Evidence-based practices in mental health services for foster youth. California Institute for Mental Health. March 2002.

²¹ *Ibid.*

²² *Ibid.*

²³ Greenough, W., Gunnar, M., Emde, N., Massinga, R., and Shonkoff, J., The impact of the caregiving environment on young children's development: Different ways of knowing. *Zero to Three*, Vol. 21, pp. 16-23. 2001.

²⁴ National Association for the Education of Young Children. Week of the young child: April 18-24. *Early Years Are Learning Years*, Vol. 99, No. 6. 1999.

²⁵ Reynolds, A., Temple, J., Robertson, D., and Mann, E., Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools. *Journal of the American Medical Association*, Vol. 285, No. 18, pp. 2339-2346. 2002.

²⁶ National Commission on Family Foster Care, A Blueprint for Fostering Infants, Children, and Youths in the 1990s. Child Welfare League of America, Washington, D.C. 1991.

PLACEMENT

Is the child placed with caregivers knowledgeable about the social and emotional needs of infants and toddlers in out-of-home placements, especially young children who have been abused, exposed to violence, or neglected?

Do the caregivers have access to information and support related to the child's unique needs?

Are the foster parents able to identify problem behaviors in the child and seek appropriate services?

Childhood abuse increases the odds of future delinquency and adult criminality by 40 percent.²⁷ Maltreated infants and toddlers are at risk for insecure attachment, poor self-development, and psychopathology.²⁸ Children in out-of-home placements often exhibit a variety of problems which may be beyond the skills of persons without special knowledge or training. Therefore, foster parents need and should receive information about the child's history and needs as well as appropriate training.²⁹ Early interventions are key to minimizing the long-term and permanent effects of traumatic events on the developing brain and on behavioral and emotional development. It is imperative that

caregivers seek treatment for their foster children and themselves as soon as possible.³⁰

Are all efforts being made to keep the child in one consistent placement?

An adverse prenatal environment, parental depression or stress, drug exposure, malnutrition, neglect, abuse, or physical or emotional trauma can negatively impact a child's subsequent development. Therefore, it is essential that all children, especially young children, are able to live in a nurturing, supportive, and stimulating environment.³¹ It is crucial to try to keep children in one, consistent, supportive placement so that they can develop positive, secure attachment relationships.

To develop into a psychologically healthy human being, a child must have a relationship with an adult who is nurturing, protective, and fosters trust and security...Attachment to a primary caregiver is essential to the development of emotional security and social conscience.³²

What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile stage for what follows.³³

²⁷ Widom, C.S., The role of placement experiences in mediating the criminal consequences of early childhood victimization. *American Journal of Orthopsychiatry*, 61 (2), pp. 195-209. 1991.

²⁸ Widom, C.S., Motivations and mechanisms in the "cycle of violence." In D. Hansen (Ed.), *Motivation and child maltreatment: Nebraska Symposium on Motivation*, Vol. 46, pp.1-37. 2000.

²⁹ National Foster Parent Association, *Board manual: Goals, objectives, position statements, and by-laws*. Gig Harbor, Washington. 1999.

³⁰ Carnegie Task Force on Meeting the Needs of Young Children, *Starting Points: Meeting the Needs of our Youngest Children*. New York, NY, Carnegie Corporation. 1994.

³¹ *Supra note 2.*

³² *Ibid.*

³³ *Supra note 15.*

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INFANT MENTAL HEALTH INTERVENTIONS IN JUVENILE COURT:
AMELIORATING THE EFFECTS OF MALTREATMENT AND DEPRIVATION

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Abstract

The juvenile court has provided a fertile opportunity for the exercise of therapeutic jurisprudence since its inception a century ago. Unfortunately, until 1997 when the Adoption and Safe Families Act (ASFA) was passed, the parent and not the child was the center of the child welfare system. With the change in dependency law after ASFA, the juvenile court has a legal responsibility to focus on the well-being and safety of the child as its paramount concern. The juvenile court, acting in concert with the community in an interdisciplinary effort, can focus on healing the child while adjudicating the case and working with the family. Since infants are now the largest cohort of children in the child welfare system, an emphasis on the needs of infants and toddlers, a previously ignored population in juvenile court, can result in true prevention of intergenerational transmission of child maltreatment.

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The parent-child relationship provides the most important context for promoting healthy child development (Sims, 2000). However, a healthy parent-child relationship is unlikely to be seen in the environment of the juvenile court. Created 100 years ago in Chicago, the juvenile court is charged with the responsibility of protecting children from the family members who have abused, abandoned, and neglected them. Juvenile court is a place of last resort where the state's interest in protecting the lives of children is more compelling than the sanctity and privacy of the relationship between a parent and child. The juvenile court intervenes to protect and rehabilitate children when all else has failed. Once the mother has reached the juvenile court, tremendous harm has already been done, the negative effects of which can only be decreased by facilitating a healing process for the child and the family. The juvenile court is in a unique position to initiate the marshalling and creation of community resources to fulfill the statutory duty of the court to heal the child.

Emerging research indicates that young children in the child welfare system are at great risk for cognitive and developmental delays (Dicker, Gordon, & Knitzer, 2001) Entry in the child welfare system may provide an opportunity for the juvenile court to evaluate and treat the child for previously undiscovered problems. The children who are under the jurisdiction of the juvenile court see doctors usually only for emergencies and have poor health care. Their parents are not able to determine the nature and extent of developmental and cognitive problems. In fact, when confronted, the parents often deny that their child has any problems.

Several studies have found that at least half of young foster children exhibit developmental delays, which is approximately four to five times the rate of developmental delay found among children in the general population (Dicker & Gordon, 2001). Without intervention, by the time these children reach school age, they will also likely be at risk for social problems in addition to their learning deficits. Observations of these children further reveal that even in

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infancy, many of the children appear uninterested in adults, unable to play, and unable to explore the world around them. Many of the children exhibit signs of traumatic stress, including withdrawn behavior, fearfulness, aggression, and sadness. It is often the case that parents do not understand these children, whose needs are significant and complex. Often the parents are overwhelmed, traumatized, substance abusing, and victims themselves, all of which lead to problems in the parent-child relationship (Lederman, Osofsky, & Katz, 2001).

At times, in Miami-Dade Juvenile Court, the task seems almost impossible, and the responsibilities of the juvenile judge to rule on the fate of children can be overwhelming. For example, each dependency juvenile judge in Florida manages a caseload of over 1000 cases a year. Since there are on average 1.7 children per case, each judge is responsible for approximately 1700 children annually. Each week, more than 100 families appear before each dependency judge, creating an apparent sea of chaos, despair, and uncontrolled emotions, ranging from anger, confusion, and desperation, to hope. It is not unknown for tears to be shed from the bench, from the lawyers' lecterns, and from the courtroom gallery.

Despite the thousands of adults and children who pass through the courts, it is rare to witness an expression of caring, love, or contrition from a parent to a child. Unlike the positive and hoped for "good enough" parent-child relationship (Winnicott, 1987), the courtroom is rarely the scene of a parental caress, a gesture of concern, or an expression of maternal or paternal pride. The juvenile courts in this country are teeming with dysfunctional families, emotional impoverishment, and every conceivable form of deprivation a child can endure. It is a difficult, if not impossible context from which to promote healthy child development that, by necessity, requires both sensitivity and the difficult task of modifying maladaptive behavior that may have become the norm in these families, passed on from generation to generation.

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Moreover, in the experience of the first author, judges who have been presiding over juvenile court cases for several years fear that the mental and emotional health of the parents and children who appear before them is declining. Consistent with this experience, there is objective evidence that behavioral and emotional problems have increased among children in the United States over the last 18 years. A recent study reports that from 1976 to 1996, clinician-identified psychosocial problems increased from 6.8% to 18.7% in all pediatric visits among 4 to 15 year olds (Kelleher, McInerney, Gardner, Childs, & Wasserman, 2000).

In addition to the necessary functions of the juvenile court to address the legal issues of custody, visitation, dependency and termination of parental rights, the court attempts to modify the behavior of the offending parent so that the family can be reunified and achieve permanency. Historically, the emphasis of the court has not been on the needs of the child.

A recent and revolutionary change in dependency law, the Adoption and Safe Families Act of 1997 (ASFA), now mandates that the safety and well-being of the child is the paramount consideration of the court in dependency decision making. States must now ensure that:

- families have enhanced capacity to provide for their children's needs,
- children receive appropriate services to meet their educational needs, and
- children receive adequate services to meet their physical and mental health needs (42 U.S.C. § 670 *et seq.*; 45 C.F.R § 1355)

The ASFA finally recognizes, in an important departure from the previous law, that reunification may not always be possible. For almost two decades, the Adoption Assistance Act of 1980 mandated reasonable efforts to reunify families. The emphasis on reunification was a legislative response to the concern about the increasing length of stay of children in foster care. While many of the tenets of the Adoption Assistance Act are unchanged, ASFA (1997) shifted the emphasis away from reunification to the safety and health of the child. ASFA imposes a one

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year deadline for judicial decisions about permanent homes for children and clearly favors the permanency option of adoption. For the first time, there is a legal understanding that reunification may not be in the best interest of all children and, in fact, could result in further harm to the child. Empirical studies of intensive family preservation services have shown that while these services represent an important part of the continuum of family support services, they may also result in child endangerment when children remain in family environments that threaten their health or physical safety (Chalk & King, 1998).

At present, children's health and safety are of "paramount concern"(AFSA, 1997, 42 USCS § 671(a)(15)) for the court in deciding what reasonable efforts should be made to reunify families. ASFA has specified services that should be provided to families, including counseling, substance abuse treatment, mental health services, domestic violence services, and crisis counseling (42 U.S.C § 629(a)). With this new emphasis, the child is finally the focus of the dependency case and not the rights of the parent over the child. The fundamental liberty and interest each parent has in the care, custody and management of their children (*Santosky v Kramer*, 1982) is not absolute.

Children in the child welfare system now have substantial new statutorily enforceable rights. In a recent decision from the U.S. District Court in the Eastern District of Wisconsin, *Jeanine B. v. McCallum* (2001), the court held that ASFA creates a federal statutory right to have the state initiate a proceeding to terminate parental rights when a child has been in foster care for 15 of the most recent 22 months. Further, the court ruled that, after termination of parental rights, the child has the right to have the state identify and approve a qualified family for adoption (Marsh, 2001). The violation of the child's newly designated rights under ASFA were deemed to create a federal civil rights cause of action under 42 U.S.C. Section 1983. More than 40% of the children in foster care are born with low birth weight or premature, more than half

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suffer from serious physical health problems, and over half experience developmental delays (Dicker, Gordon, & Knitzer, 2001). Perhaps the state's failure to provide medical and mental health services to the child will be actionable in the future.

The juvenile court has exemplified the most fertile opportunity for the exercise of therapeutic jurisprudence beginning with the creation of the first juvenile court a century ago in Chicago. The 1899 Illinois Juvenile Court Act defined a rehabilitative rather than punitive function of a court of special jurisdiction for neglected, dependent and delinquent children under the age of sixteen. Some would argue that despite the rich context for exploring the application of therapeutic jurisprudence, the juvenile court has failed to fulfill its therapeutic potential and in fact has contributed to the creation of an anti-therapeutic child welfare system (Brooks, 1999). While many lament the fact that the juvenile court, since its inception in 1899, has undergone a transformation from a therapeutic to a punitive institution, fortunately the child welfare laws, unlike laws governing juvenile delinquency, have become more child-focused. This significant change in the law provides a basis for the argument that one of the most important functions of the juvenile court, post ASFA, can be to heal the child.

An opportunity exists to create an interdisciplinary, research-based, health-focused response to ensure the therapeutic needs of the child are met and expand the bi-annual statutory judicial review hearings from a legal checkup (Brooks, 1999, p 953) to a therapeutic checkup as well. If all else fails, and the parent cannot be rehabilitated and the child returned home, at least the court can try to ensure that the child receives the therapeutic intervention he or she needs to cope with the trauma associated with maltreatment.

The child welfare system partners and the judges who preside in juvenile court must face this challenge in an environment that is devoid of science and has been created and is controlled by reactive laws. It is also an environment that often is ill-equipped to modify human behavior

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and promote healing. There is never enough time for every child (Florida Supreme Court, April 29, 1999). Complex decisions affecting the lives of children often must be made in a matter of moments.

The traditional regulations of the juvenile court can limit the ability of the court to exercise and oversee an essential therapeutic function and provide an opportunity, present and future, to change behavior. The courts' historical focus on adjudicating cases in an adversarial setting does not encourage a therapeutic inquiry or response. These limitations in concert with the level of dysfunction of the families who come before the court often create impossible challenges in enforcing the law and safeguarding the wellbeing of children. As maltreatment often is a family tradition, the result of an intergenerational transmission of neglect and abuse, the problem is extremely difficult to address effectively, especially in a court setting. The rate of intergenerational transmission of abuse is estimated to be 30% (National Research Council, 1993). One third of the individuals who were abused and neglected as children can be expected to abuse their own children. The most frustrating moment for any juvenile court judge is to witness a dependent child become the mother of a dependent child. A child mother who has never felt safe, nurtured or loved as a young child must learn to create a healthy environment and develop a loving attachment with her baby who has been removed from her. At the same time, she must address her own problems resulting from her maltreatment as a child, within the 12-month period prescribed by ASFA. How can the juvenile court fulfill its legal mandate under these circumstances, especially in an adversarial system with the limitations of huge caseloads and inadequate services? The difficulty in achieving these objectives is exacerbated by the probability that the social context within which the family lives is one of cumulative disadvantage. Success is often not feasible.

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How can the juvenile court intervene to reduce the risk of transmission of child maltreatment from generation to generation in the families under its jurisdiction? Perhaps the most effective way to stop the intergenerational cycle of child maltreatment is to focus intensively on the youngest and largest cohort of children of the child welfare population immediately upon their entry into the jurisdiction of the court. At least one-third of the children in the child welfare system are babies and toddlers under the age of six (National Center for Child Abuse and Neglect, 1997), 25 % are under age 2, and 20% are under one year of age (Dicker & Gordon, 2001). Yet the needs and problems of babies and toddlers are virtually ignored.

Directions for Making Changes in the System

The consequences of an anti-therapeutic child welfare system become more and more apparent as maltreated children become a part, albeit not a priority, of our national research agenda. Risk factors for a troubled start and uncertain future begin in the womb. Prenatal and perinatal factors present a host of latent and manifest risk factors that influence subsequent development. In fact, several studies have found an association between prenatal and perinatal complications and later delinquent or criminal behavior (McCord, Widom, & Crowell, 2001). How can a juvenile court begin to fulfill its therapeutic potential, remain within the confines of the law, and fill in the large gaps in the existence and provision of services provided by an under-funded, inadequate and often less than professional child welfare system?

To begin with, individuals who work in the child welfare system need to be educated about early intervention research and strategies that have proven effective in reducing child maltreatment and enhancing child well being. Workers in this area need to develop an understanding of the significant differences early intervention can make in child behavior, social and emotional development, mental health, cognitive development, and child health. Three

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examples of such interventions are important to note. First is the Infant Health and Development Program (IHDP), a clinical trial designed to test the efficacy of early childhood educational intervention including parental involvement and home visitation with low birth weight, premature babies in eight different sites. The results are most encouraging. After three years, the IQ levels of the children receiving intensive intervention were elevated from 6 to 13 points compared to the children in the control group who only received pediatric surveillance. Also, there were more reports of behavior problems in the children in the control group (Gross & Hayes, 1991). Second, from the Elmira Home Visitation Study, it was learned that an intensive home visitation program can result in a decrease in child maltreatment, substance abuse, and criminal behavior of the mother and the child (Olds, Henderson, Cole, Eckenrode, J., Kitzman, H., & Luckey, 1998). (It is important to note that the study concluded that effectiveness can be enhanced by careful selection and thorough training of the home visitors.) Finally, Ramey and Ramey (1998) demonstrated that early intervention greatly enhanced the development of children whose mothers had little education and lived in poverty. The program children compared with the control group children had significantly higher IQs after three years and the effects held over time. They were less likely to repeat a grade in school and showed better achievement over the years.

The important new volume on the science of early childhood development from the National Research Council and Institute of Medicine, *Neurons to Neighborhoods* (Shonkoff & Phillips, 2000), developed by an expert committee of the Board on Children, Youth and Families, emphasizes that early environments matter and that nurturing relationships are crucial for healthy development. In this context, they emphasized that all children are wired for feelings and ready to learn. But the changing needs of young children are not being met by society, which requires rethinking and creative new strategies for policy and practices. One of the

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recommendations coming out of these policy and practice concerns is that substantial new investments are needed to address young children's socioemotional and mental health needs. Essential first steps include more effective screening, early detection, treatment, and prevention strategies.

Home visitation and other types of intervention programs exist in every community funded by state and federal funds, and these programs can be accessed by the juvenile court. All pregnant mothers and children under the jurisdiction of the juvenile dependency court can be referred to home visitation programs and ordered to participate as part of the case plans. It is imperative that child welfare participants urgently shift their focus from the older child and begin to consider prevention by developing appropriate evaluation and treatment strategies for infants and toddlers. In addition to the fact that we know prevention and early intervention are important, research on early brain development shows clearly that stimulation, preferably in the context of a stable parenting relationship, is crucial for healthy development. The affection shown by parents to infants that includes touching, holding, comforting, rocking, and talking provides the best type of stimulation for the growing brain. Brain development is heavily dependent on early experience. Infants who are rarely spoken to, exposed to few toys, and who have little opportunity to explore and experiment with their environment may fail to develop fully the neural connections and pathways that facilitate later learning.

The Case of Linda and Katrina Brown: Part 1

In order to "bring to life" the discussion and illuminate some of the dilemmas faced in the juvenile court, we shall describe the situation of an actual family (except for the names and other identifying data) that is illustrative of the majority of cases that comprise the court docket day after day, especially in large urban jurisdictions. This case appeared under the jurisdiction of the first author, who is a juvenile court judge in Miami-Dade Florida.

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Linda Brown, a mother of seven children, appeared in juvenile court after her children were removed from her care. The alarming reality of the emotional and psychological harm caused to these children presents a frightening picture seen over and over again. The extent of the deprivation of the children can be understood from the report by the psychologist who examined the family members.

The children of this family have been exposed to chronic emotional neglect and are experiencing symptoms of depression, emotional impoverishment, low self-esteem, low academic achievement and aggression. There are strong indications that they have been exposed to long term family and community violence.

What can be done to prevent another generation of Brown children from facing this fate?

Linda Brown came into dependency court for the first time in 1994 when a child protection worker visited her home. At that time, her children all lived with her. They included the two oldest children, Vanessa, 11, and Katrina, 10, together with twin daughters, aged 9; a mentally retarded son, aged 7; another son, aged 4; and another daughter, aged 3. The home was fly infested, unfit for human habitation, and emitted a foul odor. The children were dirty and there was no food for them as Linda used her food stamps to support her boyfriend. A 7-year-old boy who was mentally retarded was often left alone in the home. In 1994, when this family presented to the court, the Adoption Assistance and Child Welfare Act (PL 96-272, 1980) required reasonable efforts to reunify the family as a legal priority. The health and safety of the children were a secondary concern.

Services were offered and Linda was reunified with her seven children a year later in 1995. Linda had completed a parenting class that consisted of a series of lectures where success was measured by attendance in the class, not by the attainment of insight and learned skills.

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After twelve calls to the abuse hotline (these are confidential, so their sources are not known), the children were removed again in August 1997. This time the allegations included physical abuse of the children by the mother's boyfriend. The children were living in the same filthy environment and they were found dirty and begging for food. The retarded child, now 10, was found unsupervised, in bed, wearing a dirty diaper. Linda was not home. The home was identified by local police as a frequent site of drug related activities.

In 1997, at her first appearance in court after her children were once again removed, Linda asked angrily how she could be expected to care for her seven children when she only received \$122 a month. Linda, whose I.Q. is 73, was not employed but earned money from time to time by babysitting. The children, now aged 6-14, were very closely bonded to their mother despite the fact that Linda's ability to parent was almost non-existent. Eventually, her parental rights were terminated.

The two oldest girls, Vanessa and Katrina, were removed from their mother again and placed with an aunt, and the other five children were placed in foster care. The girls were then sexually abused by the landlord when living in the home of their aunt. The girls reported that their mother's boyfriend had abused them as well. At age 14, Vanessa was pregnant and her younger sister, Katrina, was diagnosed with a venereal disease. All of the older children had dropped out of school and regularly run away from their foster homes to return to their mother, despite the fact that the mother's parental rights had been terminated and they were not permitted to reside with her.

This is not an unusual case. Children like Vanessa, Katrina and their siblings appear in every juvenile court in the United States everyday. The number of children referred to child protection agencies nationwide is staggering; almost three million children a year (National Research Council, 1993). The most serious cases result in an adjudication of dependency, in

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which children are removed from the home and the court assumes the legal role of parent.

Approximately half a million children each year are under the jurisdiction of the courts, which represents nearly two percent of the children in every community (National Council of Juvenile and Family Court Judges Report, 1997-98). In Miami-Dade County alone, this translates to 9,000 children annually (Family Safety Data Support, 2001), many of whom are infants. In Miami, 27% of the children in foster care are under the age of five (Family Safety Data Report, 2001).

In the case of the Brown family, the intervention was too little, too late. The court was unable to stop the cycle of deprivation, impoverishment, and violence from continuing from generation to generation. Vanessa and Katrina, caught in the cycle, are now child mothers. Both of their children have been removed from them by the juvenile court for virtually the same reasons they were initially taken from their mother. They are angry and they do not understand why their children cannot live with them. They have no idea what a baby needs in order to thrive and they are unable to care for their children. They are angry that something that belongs to them has been taken away.

Vanessa and Katrina have no support from the babies' fathers who have virtually abandoned the mothers and their children. The seventeen-year-old father of Vanessa's baby had dropped out of school and did not have a job. When the court asked how he spent his days, he responded, "I chill." He is now serving a prison sentence for aggravated battery. Katrina does not know the identity of the father of her child, Charles. After a paternity test was done, the man she identified as her baby's father was found not to be the biological father of the child.

Vanessa's child was removed within 2 months of birth. Vanessa was never willing to accept any services and could not overcome her own anger. She was defiant and disrespectful in

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court and refused to comply with any court order. Vanessa's parental rights have been terminated.

Katrina had been living in a foster home with her baby, Charles; however, at the age of 14 months, the child was removed from her care. Still under the jurisdiction of the court as a dependent child, the court would regularly see Katrina. She was the one child in the family who appeared to have the capacity and the desire to accept services and work with the court. When Katrina gave birth she was admonished that she would have to stay in school, cease her chronic running away, protect and care for her baby, accept mental health and parenting services or risk losing custody of her baby. At each hearing the court would implore Katrina to comply with her case plan, and she would be praised for doing well.

During one court appearance, Vanessa and Katrina, one a mother of an infant and the other a mother of a one-year-old, were asked to watch a video entitled "It Feels Good to Help My Baby Learn" (Weissbourd, 2002). They were asked to write down three things that they learned from the video about being a good parent. Vanessa and the father of her baby refused to watch the video. Katrina watched and wrote :

Don't let your child cry for a real long time. Something is wrong and when the times get to hard and you can't handle it call an adult you can trust.

Babies cannot be spoiled. Don't shake the baby -- the baby can get brain damage.

Unfortunately, Katrina began repeatedly to run away from her foster home with her baby. The last time the 15 year-old-mother and her one-year-old baby Charles were missing for two days. The baby was removed and Katrina decided to go back to her mother where she resided for several months. Katrina then disappeared for a while.

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Six months after the removal of the baby, a petition for termination of parental rights was filed. Katrina was not in compliance with any services in her case plan although she was intermittently visiting her baby.

Katrina finally appeared in court and was served with the petition for termination for parental rights. Once again, in a desire to influence Katrina's behavior, the court begged Katrina to go back to school and agree to live in a foster home. She was told what the consequence would be of her refusal to accept the court's help. Many parents in dependency court are motivated only when they learn the next step in the process is termination of parental rights.

Katrina agreed to come back into foster care. The community's private foster care provider was asked to interview Katrina for placement. Katrina enrolled in school and in parenting classes and continued to have visitation rights with her baby. In addition, she was receiving individual counseling.

Since Katrina's entry into the Miami-Dade dependency court, first as a neglected child and then as a child mother, significant systemic, research-based reform has taken place. As described below, the dependency court itself has developed state-of-the-art assessment and evaluation protocols for infants and toddlers. It has also developed a dyadic child-parent psychotherapy program for babies and their parents, and it has created additional interventions described later in this paper.

Initiatives in Miami-Dade Juvenile Court

Few jurisdictions provide court-based and court-created prevention and intervention opportunities for children and families. However, groundbreaking prevention and early intervention work is being done through a collaboration between the Miami-Dade County Juvenile Court and its early intervention partners. Several initiatives have been undertaken, with the first being a systematic examination of the developmental functioning and treatment needs in

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maltreated and violence-exposed young children.

“Prevention and Evaluation of Early Neglect and Trauma” (PREVENT)

The PREVENT initiative of the Dependency Court Intervention Program for Family Violence is a national demonstration project in the Miami-Dade Juvenile Court funded by the US Department of Justice, Violence Against Women Grants Office. PREVENT has developed a program to evaluate all infants, toddlers, and preschoolers who are adjudicated dependent by the court. During assessment sessions in a playroom setting, the parent and child are observed and videotaped engaging in a number of tasks during play interaction. Reciprocal bonding and attachment is evaluated as well as the developmental and cognitive functioning of the child. By observing these children with their caregivers and allowing them to speak through their actions, behaviors, and emotions, it is possible to understand a great deal about their development, their needs for safety and security, and the quality of their relationship with their caretaker. In the initial PREVENT study, approximately 75 children and their parents were evaluated. While the assessments on this group were considered exploratory, the information obtained was quantitatively captured in established, standardized research measures, including: the Bayley Scales of Infant Development (Bayley, 1993); the Peabody Picture Vocabulary Test used for the older children (Dunn & Dunn, 1997); the MacArthur Communicative Development Inventories (Fenson, Dale, Reznick, Thal, Bates, Hartung, Pethick, & Reilly, 1993); the Beck Depression Inventory II (Beck, Steer, & Brown, 1986); the Parenting Stress Index Short Form (Abidin, 1990); the Ages and Stages Questionnaire (Bricker & Squires, 1986); and a Parent-Child Observational Assessment and Manual modified from the Crowell Assessment (Crowell & Feldman, 1989; Crowell & Fleishman, 1991).

The group results on these measures have been used to develop a formal program evaluation plan for the PREVENT initiative as it accumulates more cases. In addition to the

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quantitative, group data, in the formal evaluation the information obtained in the assessment sessions will be qualitatively captured and analyzed, informing judges with more individualized information about the particular children and families before them. More specifically, reports generated by the evaluations will be designed to combine the quantitative and qualitative data with a focus on the appropriateness in a particular case of court referrals for infants, toddlers, and/or caregivers to early intervention and therapy programs.

“Infant and Young Children’s Mental Health Pilot Project” (IMHPP)

A second major initiative was undertaken in 2000 to build on the previous pilot program and to expand services and capacity in infant mental health in the State of Florida the project, with the Miami Juvenile Court being one of three intervention sites chosen for. State funding was allocated to the juvenile court to establish an “Infant and Young Children’s Mental Health Pilot Project” (IMHPP) for maltreated infants and toddlers. Additional sites were established in both Pensacola and Sarasota, Florida, but the Miami project is the only one of its kind in a juvenile court setting.

The pilot program includes parents and toddlers in the dependency court system who participate in an evaluation and a dyadic therapy program for 25 weekly sessions with a trained clinician. Therapeutic interventions and parental guidance are provided through the court’s early intervention partner, the University of Miami’s Linda Ray Center, and are designed to help the parents learn new ways to respond sensitively and play reciprocally with their young children, to understand their non-verbal cues, and to follow their lead, supporting healthy development. For many caregivers, the parent-child interactive play is uncharted territory as most of them did not have similar positive experiences in their own childhood. Extensive assessments are completed on the parent and child to evaluate the quality of their interactions as they begin and end the program. This is an ongoing program. The following quantitative and qualitative measures are

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being used to evaluate the program: the Bayley Scales of Infant Development (Bayley, 1993); the Peabody Picture Vocabulary Test used for the older children (Dunn & Dunn, 1997); the MacArthur Communicative Development Inventories (Fenson, Dale, Reznick, et al, 1993); the Beck Depression Inventory II (Beck, Steer, & Brown, 1986); the Parenting Stress Index Short Form (Abidin, 1990); Ages and Stages Questionnaire (Bricker & Squires, 1986); and a Parent-Child Observational Assessment and Manual modified from the Crowell Assessment (Crowell & Feldman, 1989; Crowell & Feldman, 1991).

As of this time, only preliminary data are available on approximately 38 infants and their parents. These data strongly suggest that many of these very young children are having difficulties at the basic level of thought and speech development. More than half of the maltreated infants, toddlers, and preschoolers seen so far using the PREVENT evaluation suffer from significantly delayed cognitive and language development, placing them at serious risk for learning problems, difficulty expressing their thoughts and needs to others, and a lack of ability to understand their world. However, at the end of the second year of the program, the preliminary post-test results based on observational data suggest promising improvements in parental responsiveness to their infants and toddlers both behaviorally and emotionally. The children, consistent with the increased responsivity of the caregivers, appear to show more positive emotions, more persistence, and more emotional and behavioral responsiveness.

A third year of the IMHPP funding was awarded and will extend the opportunity for continued implementation of the model with more children and parents, allowing for formal statistical analysis of the results. Complete data analysis from the three years of the program will be available in June 2003.

“Miami Safe Start Initiative”

Concurrent with the clinical IMHPP pilot activities, the Miami Juvenile Court is

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implementing the Miami Safe Start Initiative for maltreated infants and toddlers. Funding for this program was awarded to the Eleventh Judicial Circuit in Miami from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, to expand the community's ability to provide intervention services to young children who are the victims of, or who are exposed to violence in their homes and/or communities. As a result of this initiative, the first Juvenile Court Early Head Start program for maltreated toddlers is being established in Miami. A pilot group of court-referred young children, who otherwise would go underserved in early intervention programs in the community, is enrolled in the comprehensive Early Head Start program during the day and concurrently receives dyadic therapy with their primary caregiver (Lederman, Osofsky, & Katz, 2001). The dyadic therapy for the infants and toddlers in the Miami Safe Start Initiative is again provided by the court's early intervention partner, the University of Miami's Linda Ray Intervention Center.

To date, 18 children have received services and been evaluated with their caregivers on the measures listed above. Overall, mothers report low levels of depression on the Beck Depression Index. This finding, while unexpected, is not uncommon among mothers who are evaluated in conjunction with a court hearing and do not want to "look bad" for the judge. On the Ages and Stages Questionnaire, just over 71 percent of the children showed delays in at least one of the domains, with the most prevalent problems being in language and communication. On the Bayley Scales of Infant Development, on average the children scored in the borderline risk range, with a majority of them considered at serious risk for developmental delays. On the MacArthur Communication Developmental Index, used to assess vocabulary skills, the majority of the mothers reported children's expressive language to be below average. Evaluation of outcome data related to the effectiveness of the dyadic therapy and other interventions are currently ongoing. Again, as the number of children in the program increase, a more formal

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statistical analysis of the results is planned.

The Case of Linda and Katrina Brown: Part 2

Katrina and her son, Charles, who was now 2 years, 11 months old, recently appeared for a PREVENT evaluation. Charles was inhibited during the evaluation. He needed considerable encouragement from the examiner and his mother to participate. There was some concern about his receptive language skills. For example, when the examiner asked Charles to identify a particular picture in a book, Charles pointed to all of the pictures on the page. His articulation was poor and his speech was difficult to understand. He spoke in one-word sentences. From the Peabody Picture Vocabulary Test-III we learned that Charles falls within the Extremely Low range of functioning.

During the play period, the play was led by Katrina and consisted of labeling items and teaching, with minimal play interaction between Katrina and her son. Katrina appeared unable to allow Charles to explore and initiate himself. Charles was comfortable with Katrina, whose affect was neutral to positive, and they were not inhibited while playing together. Charles was content to follow his mother's lead. There were occasional smiles from Charles. When Katrina was instructed to leave the room, Charles continued playing with his toys and was not overtly distressed by his mother's absence.

Of concern were statements from Charles' day care teacher, who expressed frustration with Charles' aggressive behavior. She stated that he is very active and hits and bites other children. Charles will now be referred to an early intervention program operated by the school system for a full evaluation for adequate preschool placement and services. He will also be referred to the above-mentioned Miami Juvenile Court Early Head Start Program. In addition, Charles and his mother have begun the dyadic therapy initiated by the court through its IMHPP program, referred to above. Katrina continues to come to court and is lauded for her

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accomplishments. She is very actively involved in her school, maintains a B average, and wants to become a chef. She was recently nominated by her school for a special award for "turning her life around". Reunification with Charles appears imminent.

In sum, this new approach to prevention and early intervention can make a difference. For young mothers who have never been adequately parented and often are abused and neglected, it is not unexpected that they do not have the capacity to parent their own children. Indeed, they are continuing patterns of parenting that are familiar to them and the only ones they know. At the same time, these mothers often are attached to their babies and, although they are incapable of providing good care, do not want to lose them.

The IMHPP dyadic treatment approach focuses on the relationship between mother and baby in an effort to help the mother gain insight about how the "ghosts in her past" (Fraiberg, Adelson, & Shapiro, 1975) interfere with her being able to care for her own baby. She is able to learn not only better parenting skills, but also more about her own conflicts with her baby that may interfere with her being able to nurture the child. For example, Katrina knew that it was not good for her baby to cry for a long time; however, she did not know what to do to help the child. And it is likely that she had no help from her mother or peers about what to do.

In dyadic therapy, the mother is also able learn more about how the baby's crying may make her feel helpless and even desperate. Katrina learned through the video that it is harmful to shake her baby. However, she also needed to learn what to do through modeling, learning how to play, how to follow her baby's lead, and how to experience the pleasure of responsive interactions. In this way, and with support and guidance, Katrina may be able to take advantage of her last chance to keep her baby.

An adjunct to the therapy and parental guidance is a sensitive and responsive child care environment in the Miami Safe Start Initiative that will offer stimulation to the baby and help

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support Katrina's responsible parenting role. All of these experiences are new to a mother who was a neglected and abused child. However, we know that a comprehensive approach for the baby, mother and environment is needed to effect change.

As of this date, Katrina has shown signs of success in response to programs sponsored by this court reform. Since this has led to the Court's hope that Katrina can learn to care for and be reunified with her baby, the termination of parental rights petition has been abated. Katrina, for the last time, is being afforded the opportunity and support developed through the court to learn how to care for her baby. This time the services she will be offered are the best that any community has to offer.

The Need to Educate Judges about Early Development

Forensic examinations in court settings rarely occur before age 5 because there is a general belief that there is nothing to learn from a child until he can verbalize. Courts appear to ignore the fact that there is a tremendous amount to be learned about a baby's health, well-being, and attachment relationship by observing him, and there are virtually no tools in a court setting to conduct the observations. The Individuals with Disabilities Education Act (IDEA)(2002) provides free entitlement for multidisciplinary screening for developmental functioning (commonly referred to as "Part C" for all children under the age of 3 if there is some indication of developmental delay). Children who are delayed have an "Early Intervention Plan" (EIP), developed by the professionals with the participation of family members or custodians, and are referred to appropriate services in the community. These children are re-examined and monitored.

State child welfare agencies are often unaware of this entitlement, and young maltreated children are not being routinely referred for this assessment. That is the case in Florida. The developmental and cognitive functioning of babies is virtually ignored in the child welfare

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system. When state agencies fail, courts must step in. Courts can make the referrals for Part C evaluations when the child welfare professionals fail. However, judges do not learn about these entitlements in law school or as part of judicial education programs. Multidisciplinary partnerships and education are essential to increase judges' knowledge about such services and to give them more tools to help the many disadvantaged children that they see in the courtroom day after day.

Conclusions and Recommendations for Policy

Initiatives such as those taken in Miami-Dade Juvenile Court can be an impetus for practice and policy changes so that maltreated babies and toddlers who are rarely seen and thought about in the courtroom will become a focus of the child welfare system and juvenile court. Such practice and policy changes can serve as the impetus for a change of culture through which the needs of the youngest children who are just beginning to exhibit delays are emphasized as strongly as the needs of the older children who more often capture attention because their untreated psychosocial problems have begun to manifest significant negative sequelae.

It has become clear through the work described in this paper that the maladaptive behavior of the older child should not be the first indication of a long undiagnosed disorder. The adolescent who appears in juvenile court who has dropped out of school, repeatedly runs away from out-of-home placements, refuses services, and engages in self-destructive behavior creates an often insurmountable challenge for the juvenile judge. Judges often feel frustrated and impotent because they are unable to protect the child under the court's jurisdiction. The change in focus and culture suggested in this paper would necessitate modifications to federal entitlements to include maltreated children as a priority for services. Part C entitlement criteria for services under IDEA, determined by each state, should include children who have been

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abused and neglected. Every young child in the child welfare system should receive a Part C evaluation and be eligible to receive the rich array of services that IDEA provides as a result of an adjudication of dependency. Maltreated children often exhibit emotional and social delays that should form a basis for intervention under Part C.

Maltreated children should receive priority placement in Early Head Start and Head Start programs. For the first time, the Department of Health and Human Services established a set aside for children in the child welfare system as part of the 2002 Early Head Start funding. This promising beginning must include an examination of modifications in the programs to meet the needs of maltreated babies and toddlers and their caregivers. Maltreated children do not have parents who will advocate for them and involve themselves in a proactive way in the school curriculum and programs.

Currently, comprehensive assessments required of children in the child welfare system in Florida are only available to children five years of age and older. Ignored are the children who can be helped immeasurably by early identification and immediate intervention with problems that are just beginning to emerge. The science of early childhood development must be a basis of practice and policy to maximize the child welfare system's potential to prevent and to heal while exercising its legal mandate to ensure child well-being, instead of overseeing crisis intervention when the harm has gone untreated and undetected. Volumes like *Neurons to Neighborhoods* (Shonkoff & Phillips, 2000) must take their place beside the statute book.

The juvenile court can be the leader in gathering, organizing, and even creating community resources to fulfill the statutory duty of the court to heal the child. An important first step is to make child development research and the possibilities for prevention and intervention strategies available and understandable to the lawyers, judges and social workers who comprise the child welfare system. Through a combination of judicial leadership, consultation with

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experts, and collaboration with the pediatric and early childhood professionals in the community, prevention can be made a priority in juvenile court. Many dependent children only see physicians in the event of medical emergencies and do not receive well-child care or other professional intervention. By putting interventions in place like those described in this paper, the court can play a crucial role in ensuring, often for the first time, that all children receive a chance for success through early evaluation, treatment and monitoring to take advantage of the best resources each community has to offer. For some children and families, this will make all the difference.

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THE DEVELOPMENT AND EVALUATION OF THE INTERVENTION MODEL FOR THE FLORIDA INFANT MENTAL HEALTH PILOT PROGRAM

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ABSTRACT: The focus of this paper is on the development and evaluation of an intervention model for Florida's Infant and Young Child Mental Health Pilot Program, designed to identify families with children at risk for abuse and neglect, and to provide clinical evaluation and treatment services. The evaluation model, intervention strategies, and results presented in this paper are all part of the Florida pilot project developed as a response to the recommendations of the state's Strategic Plan for Infant Mental Health. Funded by the Florida legislature, the 3-year, multisite pilot was designed to provide earlier identification, better evaluation, and more effective treatment services for high-risk children under the age of three. The target population was children either at risk for out-of-home placement due to abuse and neglect, or those already in the child welfare system or adjudicated dependent by the state. The goals of the pilot project were: 1) to reduce the occurrence and re-occurrence of abuse and neglect; 2) to enhance the child's developmental functioning; 3) to improve the parent-child relationship; 4) to increase expeditious permanency placements; 5) to develop a model for intervention and treatment that could potentially be replicated in different sites; and 6) to document the components of a quality infant mental health intervention model and evaluate its effectiveness.

RESUMEN: Este estudio se enfoca en el desarrollo y evaluación de un modelo de intervención para el Programa Piloto de La Florida para la Salud Mental de Infantes y Niños Pequeños, el cual está diseñado para identificar a niños bajo riesgo de abuso y falta de atención, así como a sus familias, y proveerles evaluación clínica y servicios de tratamiento. El modelo de evaluación, las estrategias de intervención y

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los resultados presentados en este estudio son parte del proyecto piloto de La Florida, establecido como respuesta a las recomendaciones del Plan Estratégico del Estado para la Salud Mental Infantil. Financiado por la Asamblea Legislativa de La Florida, el programa piloto de tres años que se lleva a cabo en varios lugares fue diseñado para proveer una pronta identificación, una mejor evaluación, así como servicios de tratamiento más efectivos para niños de alto riesgo menores de tres años. La población a la cual se dirige este programa es la de niños que están ya bajo riesgo, o ya colocados en casas que no son sus propios hogares debido al abuso y la falta de atención, o que ya están bajo el sistema de beneficencia social o como dependiente adjudicado por el Estado. Las metas del programa piloto son: 1) reducir la posibilidad de que ocurra o vuelva a ocurrir el abuso o la falta de atención; 2) expandir el funcionamiento del desarrollo del niño; 3) mejorar la relación entre el niño y su(s) progenitor(es); 4) aumentar las colocaciones de permanencia expeditas; 5) desarrollar un modelo para la intervención y el tratamiento que pueda replicarse potencialmente en diferentes lugares; y 6) documentar los componentes de un modelo de intervención para la calidad de la salud mental del niño y evaluar la efectividad de tal modelo.

RÉSUMÉ: Cet article s'attache à étudier le développement et l'évaluation d'un modèle d'intervention pour le Programme Pilote de Santé Mentale du Nourrison et du Jeune Enfant de la Floride, un programme conçu pour identifier les enfants à risque d'abus et de négligence et leurs familles et également conçu pour offrir une évaluation clinique et des services de traitement. Le modèle d'évaluation, les stratégies d'intervention et les résultats présentés dans cet article font tous partie de projet pilote de la Floride, développé comme une réponse aux recommandations du Plan Stratégique pour la Santé Mentale du Nourrison de l'état. Financé par l'état de la Floride, ce projet pilote sur trois ans et plusieurs sites a été conçu pour offrir une identification plus précoce, une meilleure évaluation et des services de traitement plus efficaces pour les enfants à haut risque de moins de trois ans. La population ciblée consistait en enfant soit à risque de placement hors de leur famille à cause d'abus et de négligence, ou soit d'enfants déjà dans le système d'aide sociale ou estimé dépendants par l'état. Les buts de ce projet pilote était de: 1) réduire l'apparition et la réapparition d'abus et de négligence; 2) améliorer le fonctionnement développemental de l'enfant; 3) améliorer les relations parent-enfant; 4) augmenter les placements permanents expéditifs; 5) développer un modèle d'intervention et de traitement qui pourrait potentiellement être répliqué dans différents sites; et 6) documenter ce qui compose un modèle d'intervention en santé mentale de qualité et évaluer son efficacité.

ZUSAMMENFASSUNG: Das Augenmerk dieser Arbeit liegt auf in der Entwicklung und Evaluation eines Interventionsmodells für Floridas Kleinkindprogramm für die seelische Gesundheit, erstellt, um Kinder, die in Gefahr sind missbraucht, oder vernachlässigt zu werden zu identifizieren und für sie eine Untersuchung und Behandlung vorzuhalten. Das Evaluationsmodell, die Interventionsstrategien und die Ergebnisse dieser Arbeit sind alle Teil des Pilotprojekts, das als Antwort des Plans des Bundesstaats Florida zur Verbesserung der seelischen Gesundheit geschaffen wurde, bezahlt von der Legislative Floridas. Es läuft drei Jahre. Dieses Projekt wurde entwickelt, um eine frühere Erkennung, bessere Evaluation und effektivere Behandlung für Hochrisikokinder unter drei Jahren zu haben. Die Zielpopulation waren Kinder mit dem Risiko einer Fremdunterbringung wegen Missbrauch, oder Vernachlässigung, oder die, die bereits im Wohlfahrtssystem waren, oder pflegschaftsrichterlich behandelt wurden. Die Ziele dieser Vorläuferstudie waren: 1) Das Auftreten und die Wiederholung von Missbrauch und Vernachlässigung zu verhindern; 2) Die Entwicklung des Kindes zu verbessern; 3) Die Eltern Kind Beziehung zu verbessern; 4) dauerhafte Pflegesituationen zu fördern; 5) Ein Modell zur Intervention und Behandlung zu entwickeln, das auch woanders repliziert werden kann; 6) Die Komponenten eines qualitätsvollen Interventionsprogramms im Bereich der seelischen Gesundheit des Kleinkinds zu dokumentieren und ihre Effektivität zu evaluieren.

抄録：この論文の焦点は、虐待とネグレクトの危険性の高い子どもとその家族を発見し、臨床的な評価と治療サービスを提供するためにデザインされた、フロリダの乳幼児精神保健パイロット・プログラムFlorida's Infant and Young Child Mental Health Pilot Programのために、介入モデルを開発し、評価することである。この論文に提示された評価モデル、介入戦略、そして結果は、すべてフロリダパイロット・プロジェクトの一部であり、それは州の『乳幼児精神保健のための戦略プラン』の勧告への応答として開発された。フロリダ州議会によって創設された、3年間の多施設で行われるパイロット・プロジェクトは、3歳未満の危険性の高い子どものために、より早期の発見、よりよい評価、そしてより有効な治療サービスを提供するようにデザインされた。標的となる対象は、虐待とネグレクトのために家庭から離す措置out-of-home placementの危険性が高い子ども、あるいはすでに児童福祉システムにいるか、州によって保護されると判決が出ている子どものいずれかである。パイロット・プロジェクトのゴールは、以下の6つだった。1) 虐待とネグレクトの発生と再発を減少させること、2) 子どもの発達機能を促進すること、3) 親と子の関係性を改善すること、4) 迅速な永続的措置 permanency placementsを増加させること、5) 別の拠点でも再現できる可能性のある介入と治療のモデルを開発すること、そして6) 良質の乳幼児精神保健介入モデルの構成要素を記録し、その有効性を評価すること。

* * *

The focus of this paper is on the development and evaluation of an intervention and treatment model for Florida's Infant and Young Child Mental Health Pilot project. The project was designed to identify families with children at risk for abuse and neglect and to provide clinical evaluation and treatment services. In this paper, the problems facing the target population of children are described, an overview of relevant literature is reviewed, the approach utilized to address the problems is presented, and the process, evaluation, and treatment model and outcome results are presented. The paper also describes the evolution of the Miami Court Team Program that grew out of the original pilot project.

DEFINING AND ADDRESSING THE PROBLEM OF ABUSE AND NEGLECT

Every year, approximately one million cases of child abuse and neglect are substantiated in the United States (U.S. Department of Health and Human Services Administration on Children, Youth, and Families, 2005). It is likely that the actual rate of abuse and neglect is much higher than the numbers in official records. Forty-five percent of these children are under the age of 5 years, comprising the largest percentage of maltreated children. Infants and toddlers make up one third of all admissions into the child welfare system and once they are in care, young children remain longer and are more likely to be abused and neglected (Wulczyn, Hislop, & Harden, 2002). Further, each change in social worker reduces the chances of permanency by 52% (National Clearing House on Child Abuse and Neglect, April 2006). Young children are also more vulnerable than older children. For example, in 2004, children

under 4 years accounted for 79% of child fatalities, and children under 1 year accounted for 44% (US Department of Health and Human Services, Administration on Children, Youth and Families, 2005).

Research shows that abuse and neglect impacts children negatively, affecting their physical, cognitive, social, and emotional development. Developmental delays occur at a much higher rate in these children than in the nonabused population, and they also have a much higher incidence of behavioral problems (Leslie et al., 2005). As they grow older, these children are at higher risk than nonabused children for problems in school including behavioral difficulties, truancy, delinquency, and risk-taking behaviors such as substance abuse and mental illness (Widom & Maxfield, 2001). At least half of all children who are maltreated will experience school problems (Eckenrode, Laird, & Doris, 1993). There is increasing evidence that multiple traumas such as maltreatment combined with exposure to other types of violence, such as domestic violence, can affect children even more negatively including lowering a child's IQ (Knitzer, 2000; Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003). The social and educational consequences of maltreatment start early in childhood and continue into later development. The Infant and Young Child Mental Health Pilot Project was designed to address the very serious issue of intergenerational abuse and neglect that is seen both in juvenile court and in the child welfare system. Not infrequently in juvenile dependency court, a young parent who has grown up in the child welfare system appears before the judge, unable to parent her own child who has been adjudicated dependent due to abuse and neglect. She repeats what she knows. As Roy Muir states it, "Parenting comes naturally—but it comes naturally the way you learned it" (When the Bough Breaks, 1995). Maltreatment not only leads to increases in aggression, depression, and other deviant social behaviors such as school dropout, but in addition, the personal costs and financial obligations for society are very significant.

THE IMPORTANCE OF THE EARLIEST RELATIONSHIP

Despite considerable scientific and research evidence (Shonkoff & Phillips, 2000), discussions on children's mental health have consistently excluded babies and toddlers, focusing instead on school-age children and adolescents. Unfortunately within the public mental health system, the majority of mental health professionals who provide services for children know relatively little about those under the age of 6 years. It is important to recognize, however, that babies and toddlers have many ways of communicating without necessarily using language and that mental health professionals are able to assess their social and emotional needs. In the infant mental health field, many say that play is the language of young children.

Attachment is one of the most critical developmental tasks of infancy. The science of early childhood development tells us that early relationships and attachments to a primary caregiver are the most consistent and enduring influence on social and emotional development for young children, and that early relationships form the basis for all later relationships (Bowlby, 1988; Emde, 1991; Shonkoff & Phillips, 2000). Young children are generally more vulnerable than older children to experiences beyond their control and, therefore, cannot self-regulate their behaviors and emotions to the same degree as older children (Osofsky, 2004). Infants and young children depend on a caregiver-infant system that serves to protect them (Bowlby, 1969; Masten & Gewirtz, 2006). Infants and toddlers who are able to develop secure attachments that help them develop the capacity to self-regulate are observed to be

more positive in their interactions with adults and peers than children who lack secure attachments. These early relationships can also have an impact on how they relate to others in adulthood (Waters, Merrick, Treboux, Crowell, & Altersheim, 2000). The caregiver is a source of responsive, predictable, and comforting emotion regulation. When the attachment relationship is secure, the infant experiences relatively short periods of distress and can be comforted easily. Stimulation is appropriate to the infant's capacity to manage, and the infant and caregiver develop flexible physiological and emotional communication (Sroufe, 1996). These infants and young children may also develop a more positive self-concept, more advanced memory processes, and a better understanding of emotions. Alternatively, unresponsive, frightening, and/or chaotic caregiving are associated with insecure and disorganized attachments, leaving the infant vulnerable with less ability to self-regulate arousal and distress. These infants develop disturbed patterns of dyadic regulation in their responses to the environment and stress (Kochanska, 2001; Lieberman & Zeanah, 1995; Sroufe, Carlson, Levy, & Egeland, 1999). Studies of brain plasticity in relation to early social experiences also suggest vulnerabilities in the developing child's capacity to respond adaptively to stress (Shonkoff & Phillips, 2000). Thus, the caregiver-infant relationship is a key to both vulnerability and protection in early development. Infants who do not have an opportunity to form a reliable attachment with a trusted adult (for example, infants and toddlers who experience multiple foster homes) may suffer grave consequences. Without intervention, their development can deteriorate, resulting in delays in cognition and learning, relationship dysfunction, difficulty expressing emotions, school problems, and even future mental health disorders or delinquency (Eckenrode, Laird, & Doris, 1993; Dodge, Bates & Petit, 1990; Widom & Maxfield, 2001; Larrieu & Zeanah, 1998).

Unlike adults, babies and toddlers have fairly limited ways of responding to stress and trauma. They may respond through inconsolable crying, withdrawal from daily activities, sleeplessness or lack of appetite due to depression, anxiety, and traumatic stress reactions. Older toddlers may show aggressive behavior, sleep problems, and behavior dysregulation (Cicchetti & Toth, 1997; De Bellis & Van Dillen, 2005; Osofsky, 2004). If the underlying causes of the stress are not addressed, they can develop into serious mental health disorders, including depression, attachment disorders, and traumatic stress disorder. Infants can experience withdrawal and depression as early as 4 months of age (Luby, 2000). Unfortunately, despite the severe consequences, these disorders are not being identified. Neither parents nor most providers know enough about how to identify the early warning signs to make effective referrals. Further, for those who want to refer children for mental health services, there are very few evidence-based services available for babies and toddlers in most communities.

Babies do not exist in isolation. The parent's mental health can also affect the young child. Conditions such as maternal depression and anxiety disorders can disrupt parenting. For example, infants of mothers who have severe chronic, untreated depression often withdraw, ultimately affecting their language skills, as well as physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulty in school (Embry & Dawson, 2002). Fraiberg and her colleagues' (Fraiberg, Adelson, & Shapiro, 1975) important work on "ghosts in the nursery" provides insight on understanding the immediate effects on young children and their families as well as their subsequent reactions. For children exposed to trauma, retraumatization can play a very significant role. Children who have experienced previous losses may have much more serious mental health reactions to a current trauma (Pynoos, 1993; Knitzer, 2000). Further, Fraiberg

et al. (1975) emphasized how unresolved issues of parents can interfere with and confound their ability to provide loving supportive relationships with their own baby.

PROVIDING INFANT MENTAL HEALTH INTERVENTION IN THREE FLORIDA COMMUNITIES: STRUCTURE OF THE PILOT PROJECT

As mentioned above, children under age 5 comprise the largest percentage of age groups of maltreated children (Wulczyn, Hislop, & Harden, 2002; Dicker and Gordon, 2004). Many of these young children have both developmental and mental health problems, but typically must wait until school age when their problems are much more severe before they are identified or receive services.

The focus of this paper is on Florida's efforts to identify these children early and to provide clinical evaluation and treatment services for both the young children and their caregivers. The Florida legislature funded a 3-year, multisite Infant and Young Child Mental Health Pilot Project designed to provide earlier identification, better evaluation, and more effective treatment services for high-risk children. The children in the project were either at risk for out-of-home placement due to abuse and neglect, or were already in the child welfare system and judged dependent by the state but for whom parental rights had not yet been terminated. This paper also includes a description of the Miami Court Team Model Program that has not only continued the work of the initial Florida Infant Mental Health Pilot Program but also has expanded it in important directions.

The primary goal of the pilot project was to reduce the occurrence and reoccurrence of abuse and neglect, enhance the child's developmental functioning, and increase expeditious permanent placements. A secondary goal was to develop a model for intervention and treatment that could be replicated in different sites, document the components of quality infant mental health interventions, and evaluate their effectiveness.

METHOD

Site Selection

Three geographically diverse sites were chosen within Florida: Miami, an ethnically diverse urban city (a collaborative project between the Dependency Division of the Juvenile Court, Eleventh Judicial Circuit, and the University of Miami's Linda Ray Intervention Center); Sarasota, one of the most affluent communities in the state (Child Development Center); and Pensacola, in the rural Florida Panhandle (Lakeview Community Mental Health Center). Each site committed to recruiting 25 high-risk infants and toddlers, ranging in age from birth to 48 months and their parent(s); however, the actual range extended to 52 months at intake because the three sites served different populations and recruited in different ways. The sample size also differed by location; this was expected considering the population differences across sites. All sites agreed to participate concurrently in extensive infant mental health training for their therapists and to follow the evaluation and treatment protocols.

TABLE 1. *Reasons Participants Did Not Complete Treatment*

Reason for Not Completing Treatment	Numbers Not Completing Treatment
Caregiver lived out of the service delivery area and never attended appointments	14
Caregiver's rights were terminated	6
Family could not be contacted for appointment	4
Caregiver was incarcerated	3
Caregiver did not cooperate	2
Caregiver's location was unknown	2
Case was closed and treatment was not mandated	2
Transportation was not available and school-based treatment was not possible	1
Caregiver died	1
Reason was unknown (likely some reasons were similar to those listed above)	23

Participants

The sample of mothers included in this study was particularly high risk; the parents had either maltreated their children who were adjudicated dependent¹ or they were at high risk for abuse/neglect of their young child, having been identified by the child protection system. Fifty-nine percent of the sample was court-ordered to participate (and made up the Miami Court Team sample); others were referred from the Department of Children and Families (child protection), pediatricians, and community sites because of risk of maltreatment, and their participation in the program was voluntary.

One hundred twenty nine child-caregiver pairs were referred during the 3-year project. Seventy-five dyads were recruited in Miami, all referred from Juvenile Dependency Court; 29 were recruited in Sarasota, referred by the Department of Children and Families and primary care physicians; and 25 were recruited in Pensacola, mainly from the Department of Children and Families. Of those referred, 72 dyads were noncompliant from the onset or dropped out of treatment. They came from the three referral sources, those who were court-ordered, child welfare referred, and referred by primary care providers. Such attrition is not unexpected for such a high psychosocial risk sample where substance abuse, parental mental illness or low functioning, and homelessness were common.

Fifty-seven dyads completed treatment; of these, 29 (38%) were from Miami, 19 (65%) were from Sarasota, and 9 (36%) were from Pensacola. The lower attrition rate in Sarasota probably relates to the difference in socioeconomic status, with those parents having slightly more education and probably more motivation than the others. Of the 57 dyads that completed treatment, 50 also completed the pre- and post-assessments. We obtained data on reasons for

¹Only a juvenile court judge can declare, based on clear and convincing evidence, that a child is dependent. A child who has been declared dependent may be removed from his/her home by the court and placed in a facility for dependent children.

noncompliance or dropout for 58 of the 72 dyads (see Table 1). The remaining 14 were referred, but did not come in for the assessment.

Full or partial demographic data were available for 110 of the 129 referred mothers. Mothers ranged in age from 14 to 42 with a mean age of 24.33 years old (standard deviation [SD]=6.22). Thirty-nine percent of the mothers were in an ongoing relationship with the child's father. The sample of mothers included in this study was particularly high risk, as 49% dropped out of high school before graduating or obtaining a GED, and 52% of the mothers had been incarcerated.

Full or partial demographic data were available for 117 children. At intake, children ranged in age from 1 to 52 months (mean age=19.39, SD=9.97); 57% were male, and 43% were female. They were a racially diverse group; 51% were Black/African American, 21% were Caucasian, 17% were Hispanic, 8% were biracial, and 3% were classified as other.

Forty-six children were included in the final analysis. Children ranged in age from 2 to 52 months at intake (mean age=20.19, SD=10.91). Thirty children were male, and 16 were female. Twenty-two children were Black/African American, 13 children were Caucasian, 7 were Hispanic, 3 were biracial, and data was not available for one child. Of the 46 dyads included in the analyses, number of treatment sessions attended ranged from 8 to 92 with a mean of 27 sessions. The number of sessions varied due to clients' missing appointments, resulting in differences in time between sessions. However, change in parent-child interaction assessed after 25 sessions (or in a few cases at the end of their shorter treatment) was not related to the amount of time it required to complete the sessions.

In order to study differences between the participants who completed treatment and those who were noncompliant, the groups were compared on pertinent variables. Complete data were not available for all participants. *T*-tests were used to test continuous data, 2×2 chi-square with Yates correction were used for discrete data, and Fisher's exact probability tests were used to test discrete data with fewer than five cases per cell. Results showed that mothers who completed high school were more likely to complete treatment (see Table 2).

Procedure

The referral procedures differed in the three sites. In Miami, infants, toddlers, and their caregivers were referred from Miami Juvenile Dependency Court. In Sarasota and in Pensacola, they were referred from the Department of Children and Families, pediatricians, and community sites. All dyads referred to the program were evaluated using a relationship-based assessment (described in detail below) as well as a number of self-report measures. After the assessment, if the parent or caregiver consented to participate in weekly dyadic relationship-based treatment, and if one of the following conditions was not present, the infant/toddler and caregiver were referred for therapy. If the mothers suffered from mental illness, if they were not being compliant with substance abuse treatment, if they were homeless, or if the parent was incarcerated, they were not referred for therapy.

TABLE 2. Demographic Characteristics by Group^a

	Dyads that completed treatment (n=57)	Dyads that were noncompliant with treatment (n=58)
Child's age in months at intake	Mean=20.48 SD=10.88 (n=56)	Mean=18.40 SD=8.66 (n=49)
Mother's age at intake ^b	Mean=25.31 SD=6.15 (n=49)	Mean=23.55 SD=6.60 (n=49)
Child's gender (Male:Female)	38:19 (n=57)	25:25 (n=50)
Child's race (Caucasian:Minority ^c)*	16:40 (n=56)	5:44 (n=49)
Maternal education (Completed high school:Did not complete high school)*	33:20 (n=53)	20:27 (n=47)
Mother ever incarcerated (Yes:No)	26:27 (n=53)	24:22 (n=46)
Mother and father in an ongoing relationship (Yes:No)	23:30 (n=53)	14:33 (n=47)
Caregiver depression ^d	Mean=12.78 SD=9.59 (n=46)	Mean=11.52 SD=8.64 (n=23)

* $p < 0.05$.^aFrequencies are reported for discrete data, means and standard deviations for continuous data.^bMother's age in years.^cMinority includes Black/African American, Hispanic, Biracial, and Other.^dDepression based on pre-assessment BDI raw score.

Evaluation

The pre- and the post-assessment protocols included qualitative and quantitative measures. The research component of the program was reviewed and approved by the Internal Review Boards (IRBs) of the University of Miami and Louisiana State University Health Sciences Center.

Modified Parent-Child Relationship Assessment. The Modified Parent-Child Relationship Assessment (Crowell & Fleishman, 1993) was done at the time of referral, before the initiation of treatment, and after 25 treatment sessions or at an earlier session if no further treatment was deemed necessary. Parental informed consent was obtained for the assessment, including consent to videotape for educational and research purposes. While treatment may not have been completed after 25 sessions, it was decided that a post-treatment evaluation was needed at a standard time for all dyads. The modification of the original Crowell assessment was structured as shown in Table 3.

Scoring for the Modified Parent-Child Relationship Scales. The coding scales used for the evaluation were based on a modification of the original Crowell scales (Crowell & Chase-Landsdale, 1999) by Heller, Aoki, and Sheffner (1999) that were further modified and adapted for this study by Osofsky, Bosquet, Kronenberg, and Hammer (2003). (The Parent-Child Relationship scales are available from the first author.) Specifically, caregivers' behaviors and emotions were coded on a 5-point scale for the free play and structured play segments. For all scales, 5 is the most optimal score, and 1 is the least optimal score. Caregivers were scored on

TABLE 3. *Modification of the Original Crowell Assessment*

Prior to assessment	Parents/caregivers are given instructions about the assessment, told what to expect, and informed that they will receive further instructions between each episode. Individual tasks are demonstrated to the parent/caregiver.
Free play: 8–10 minutes	Instruction: “Play with the child as you would at home.”
Cleanup: no more than 5 minutes	Instruction: “Have the child clean up, helping him/her if you feel your child needs help.”
Bubbles: 3–5 minutes	Instructions: “Use the bubbles to play with your child.”
Task 1: 2–4 minutes	Specific tasks instructions are given. (This task is slightly below child’s developmental level. Although the caregiver is not told, the child will likely be able to complete the task independently.)
Task 2: 2–4 minutes	Specific tasks instructions are given. (Task is slightly below or at child’s developmental level.)
Task 3: 3–5 minutes	Specific tasks instructions are given. (Task is slightly above or at child’s developmental level.)
Task 4: 3–5 minutes (if used)	Specific tasks instructions are given. (Task is slightly above child’s developmental level. Although the caregiver is not told, the child will likely need help to complete the task.)
Separation: no more than 3 minutes (Have parent take bubbles)	Instructions: “Open the cabinet doors, so that the child can see the task toys and then leave the room as you would at home.”
Reunion: 3 minutes	Instructions, “Knock on the door, call the child’s name, and step all the way into the room.” The parent and child return to play.

positive affect (e.g., smiling, laughing), ranging from 1 (no or low positive affect) to 5 (high positive affect); *withdrawal/depression*, ranging from 1 (high withdrawal/depression) to 5 (no or low withdrawal/depression); and on *irritability/anger/hostility* toward the child, ranging from 1 (high irritability/anger/hostility) to 5 (no or low irritability/anger/hostility). Caregivers’ behaviors during the structured play segments were coded on the following scales: *Intrusiveness*, ranging from 1 (very highly intrusive) to 5 (very low intrusive), was defined as the caregiver’s ability to follow the child’s lead and be sensitive to the child’s pacing and physical space. *Behavioral responsiveness*, ranging from 1 (poor responsiveness) to 5 (optimal responsiveness), was defined as the caregiver’s ability to structure the play and tasks in ways that were developmentally sensitive to the child’s needs and to help the child maintain emotional regulation. *Emotional responsiveness*, ranging from 1 (poor emotional responsiveness) to 5 (outstanding responsiveness), was defined by the caregiver’s ability to create a positive, warm, and supportive emotional environment for the child and prevent the child from becoming overly distressed or frustrated. Caregivers’ discipline strategies during the structured task were also scored, including their use of positive discipline, ranging from 1 (no or very low positive discipline) to 5 (very high positive discipline; e.g., modeling the correct behavior, praising the child for success) and negative discipline, ranging from 1 (very high negative discipline) to 5 (no or very low negative discipline; e.g., shaming the child, physically threat-

ening the child). Children's emotions were also scored using a 5-point scale. Affective responses including positive affect, withdrawal/depression, anxiety/fear, irritability/anger/hostility, and enthusiasm were scored. Children were also scored on a 5-point scale for aggression and noncompliance towards the caregiver and on persistence during the structured tasks. During the brief separation and reunion, caregivers and children's behaviors were rated. Caregivers were coded on their ability to provide sensitive comfort to the child, to minimize the child's distress, and to help the child return to play and exploration (caregiver's emotional and behavioral responsiveness). The children were coded on their ability to self-soothe, be comforted in response to parental support, and return to play (child's emotional and behavioral responsiveness).

Three coders who were not involved with the pilot project scored the tapes using the Parent-Child Relationship Scales (Osofsky, Bosquet, Kronenberg, & Hammer, 2003). Two raters were trained by a master rater who was involved in the modification of the scales, and reliability was achieved during training when the two raters' coding matched the coding of the master rater for five dyads. Inter-rater agreement between the two raters was then established based on independent coding of a third of the tapes. Reliability was based on blind coding, meaning the raters did not know which tapes were pre- or post-assessments. Paired r values for each scale ranged from .87 to 1.0 (mean $r = .96$).

Child Developmental Status. Children's developmental status was measured using the Ages and Stages Questionnaire (ASQ). The ASQ is a screening system designed to identify children who may be developmentally delayed and in need of further assessment and potentially early intervention services. It measures child's functioning in five domains: communication, gross motor, fine motor, problem solving, and personal-social (Squires, Potter, & Bricker, 1999). Each domain has six items, and each item is scored as "yes" (10 points), "sometimes" (5 points), or "not yet" (0 points). Scoring is based on a cutoff score. Children who are above the cutoff are considered to be within normal limits for that domain of functioning; children who are below the cutoff score (two standard deviations below the mean) are considered at risk and in need of further evaluation.

Beck Depression Inventory. The Beck Depression Inventory (BDI-II) was used to measure depressive symptomatology in caregivers. The BDI-II is a 21-item self-report instrument that measures the presence and severity of depressive symptoms in adults and adolescents. The BDI-II discriminates between depressed and nondepressed individuals (Beck, Steer, & Garbin, 1988) and yields a total score ranging from 0 to 63 that discriminates between mild, moderate, and severe depression.

Parenting Stress Index. Caregiver report of the parent-child relationship was measured by the Parenting Stress Index-Short Form (PSI-SF). The PSI-SF, a 36-item scale, measures Total Stress as well as three subscales, Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. It also has a validity subscale (Defensive Responsiveness) to determine the amount of response bias (Abidin, 1992). Total Stress and each subscale are scored according to raw scores and percentiles. A percentile score of 85% or above indicates significant stress in that domain.

Caregivers' and Therapists' Qualitative Impressions of Treatment. Following treatment, car-

TABLE 4. Pre- and Post-Treatment Means, Standard Deviations, Significance Levels, and Effect Sizes on Components of the Modified Crowell Parent-Child Relationship Procedure

	Number of dyads included in the analysis	Pre-treatment mean (<i>M</i>), standard deviation (SD)	Post-treatment mean (<i>M</i>), standard deviation (SD)	Paired Sample <i>t</i>	<i>p</i> value	Effect size ^a
Caregiver Variables						
Positive affect	46	<i>M</i> =3.42 SD=0.82	<i>M</i> =3.45 SD=0.76	-0.19	.85	.04
Withdrawn/depressed	46	<i>M</i> =4.63 SD=0.59	<i>M</i> =4.53 SD=0.71	0.92	.36	.17
Irritability/anger/hostility	45	<i>M</i> =4.29 SD=0.82	<i>M</i> =4.53 SD=0.77	-2.12	.04	.29
Intrusiveness**	45	<i>M</i> =2.98 SD=1.09	<i>M</i> =3.71 SD=0.86	-5.21	<.01	.67
Behavioral responsiveness**	46	<i>M</i> =3.01 SD=0.93	<i>M</i> =3.57 SD=0.83	-4.01	<.01	.60
Emotional responsiveness**	46	<i>M</i> =3.02 SD=0.78	<i>M</i> =3.46 SD=0.74	-3.93	<.01	.56
Positive discipline**	38	<i>M</i> =3.42 SD=0.79	<i>M</i> =3.97 SD=0.79	-3.48	<.01	.70
Negative discipline	38	<i>M</i> =4.21 SD=0.99	<i>M</i> =4.42 SD=0.86	-1.19	.24	.21
Caregiver emotional and behavioral responsiveness at reunion**	39	<i>M</i> =3.21 SD=1.06	<i>M</i> =3.69 SD=0.92	-2.98	.01	.45
Child Variables						
Positive affect**	46	<i>M</i> =3.06 SD=0.98	<i>M</i> =3.53 SD=0.79	-3.77	<.01	.48
Withdrawn/depressed	46	<i>M</i> =4.39 SD=0.91	<i>M</i> =4.51 SD=0.86	-0.72	.48	.13
Anxiety	46	<i>M</i> =4.74 SD=0.56	<i>M</i> =4.83 SD=0.49	-0.98	.33	.16
Irritability/anger/hostility	46	<i>M</i> =3.99 SD=0.98	<i>M</i> =4.27 SD=0.66	-1.91	.06	.29
Noncompliance	45	<i>M</i> =3.79 SD=0.90	<i>M</i> =3.92 SD=0.64	-0.96	.34	.14
Persistence	38	<i>M</i> =3.58 SD=1.13	<i>M</i> =3.97 SD=1.10	-1.86	.07	.35
Child emotional and behavioral responsiveness at reunion*	39	<i>M</i> =3.13 SD=0.95	<i>M</i> =3.51 SD=0.97	-2.43	.02	.40

*Nonsignificant trend towards improvements between pre- and post-data collection points.

**Statistically significant improvement between pre- and post-data collection points. Based on Bonferroni adjustments, the significance level was set at $p=.01$ for both caregiver and child variables.

^aInterpretation of effect size is as follows: $\geq .80$ =large; $\geq .50$ =medium; $\geq .20$ =small (Cohen, 1988).

egivers were asked a number of questions in order to qualitatively examine the caregiver's experiences of the treatment and its effects. The questions and responses are listed in Table 4. Therapists were also asked to describe their experience of treatment and its impact on the families served.

Treatment Program

An assumption of the program, incorporated into the treatment component, is that the young child has been harmed in the relationship through abuse and neglect and must be healed in the relationship. Abuse and neglect leads to lack of trust and difficulties in attachment that can best be addressed by repairing the damage that has been done and, together with the caregiver, working to create a new narrative for the parent and child to move forward.

Child-Parent Psychotherapy (CPP), which engages both child and parent working together, is the relationship-based treatment program implemented for the project (Lieberman & Van Horn, 2004). CPP is an evidence-based, relationship-based intervention for children aged birth through 5 years who are showing mental health or behavioral problems, including symptoms of post-traumatic stress. It is based on the premise that the child's relationship with the mother or primary attachment figure represents the most expeditious port of entry to alleviate the child's psychological difficulties, promote age-appropriate affect regulation, and restore developmental momentum. The interventions promote affect regulation in the child, the parent, and their interaction. CPP has been shown to be effective in two independent studies, one by Lieberman, Ghosh-Ippen, and Van Horn (2006) and the other by Toth, Maughan, Manly, Spagnola, & Cicchetti (2002). The Lieberman et al. (2006) study provides evidence for the efficacy and durability of CPP evaluated with paper-and-pencil outcome measures with multiethnic preschool-age child-mother dyads from diverse economic backgrounds when compared with case management plus community referral for independent treatment. The Toth et al. (2002) study, using a narrative story-stem task, evaluated the efficacy of CPP to psychoeducational home visitation or community standard intervention. They found that CPP resulted in a greater decrease in maladaptive maternal representations as well as negative self-representations. In addition, the mother-child relationship expectations became more positive over time.

CPP is a multitheoretical approach that integrates attachment, psychoanalytic, and trauma theory with intervention strategies derived from cognitive-behavioral and social-learning therapies. Attention to the cultural values of the parents and the family is an integral component of the intervention plan and is woven into all of the principal components of the intervention. The principal components of CPP are:

1. Joint sessions centered on the child's free play with carefully selected therapeutic toys in order to facilitate focus on the child's trauma experience and on the child-parent interaction, with individual collateral sessions with the parent as needed.
2. Translating the developmental and emotional meaning of the child's behavior to the parent in order to increase parental understanding and empathy.
3. Targeting for intervention affect dysregulation in the child and the parent, maladaptive child behavior, parenting patterns that are punitive or developmentally inappropriate, and patterns of parent-child interaction that reflect mistrust and misunderstanding of each other's developmental agendas.

4. Fostering joint parent-child activities that promote mutual pleasure and the child's trust in the parent.
5. Employing a variety of intervention strategies that are individually tailored to the needs of the child and the parent. These strategies include developmental guidance, role modeling, emotional support, crisis intervention, assistance with problems of living, and insight-oriented intervention.
6. Starting with the most simple and direct intervention strategies, with more complex modalities such as insight-oriented interventions used only when simpler interventions are not successful in producing child improvement.

Incorporated in CPP work with the parent-child dyad is "speaking for baby" as an additional intervention to help sensitize the caregiver to the young child's feelings (Carter, Osofsky, & Hann, 1997). This therapeutic strategy allows the therapist to express what the baby may be feeling in words to help the mother understand what the child's play and behaviors may mean. Often, it is very difficult for mothers who experienced poor mothering and other adversities themselves to be empathic with the babies' feelings. Also, many do not know how to understand what behaviors and emotions may mean. "Speaking for baby" incorporated into dyadic CPP therapeutic interventions provides a strategy to help the parents gain understanding and empathy for their children and is an indirect way to influence changes in parenting behavior. It can dramatically change the parent's understanding of the child and the meaning of behaviors and emotions.

If the trauma that the child has experienced is difficult at first for the parent to hear or see through play, play therapy may be used as an adjunct to parent-child psychotherapy to allow the child the opportunity to play out and work through the trauma. When the parent is ready, she will join the play as a way of creating a new way of being together, thus creating a more positive relationship. Play therapy may also assist with self-regulation and appropriate expression of emotion.

Another main component of the work with parents involves parental psychoeducation to help the mother learn skills for nurturing and caring for her child and to allow her to ask questions about her child. Parental guidance and other work with the parent include teaching and modeling appropriate expectations and interactions relative to the child's developmental needs. Exploration and raising awareness of the parent's own unresolved issues from childhood that might be interfering with attachment and her attitude toward her child is also stressed (Fraiberg, Adelson, & Shapiro, 1975). Case management that may include help in finding child care for the child, and even help with housing used in conjunction with psychoeducation contributes to growth in the parent and the success of the program. Activities may include home visiting, visiting the child at child care, and helping to arrange transportation or communicating with the Department of Children and Families. The treatment plan also may include referral for other services. In addition, the project required extensive engagement services necessary to maintain the therapeutic work.

Ongoing screening was done for possible parental substance abuse, domestic violence, mental illness, and parent and/or child cognitive deficits that could interfere with the parent's ability to parent effectively. This information was used to inform treatment planning.

Post-Assessment Following Treatment

The decision was made to do a post-assessment after 25 sessions in order to ensure consistency for the evaluation component. A period of 25 sessions was chosen due to the variable time frame that was part of the treatment program. Some parents engaged right away and were consistent with treatment each week; others took some time to engage; still others were consistent for a while and then something happened in their lives that interfered with their consistency. Some child-parent dyads completed treatment before the 25 sessions and the post-treatment evaluation was done at that time. If child-parent dyads required additional treatment after the 25-week assessment, continuation was offered.

RESULTS

Main Findings

First, there were no further reports of abuse or neglect during the treatment period and up to post-assessments for participants. There was a major reduction in reports of child abuse and neglect to the Department of Children and Families (DCF-Child Protection), from 97% of children prior to treatment to none of the children completing treatment during the first 3 years of the pilot project. There was only one call to the DCF hotline pertaining to a participant and it was unsubstantiated. Second, there were permanency placements of either reunification with the parent or a family member for all children completing the child-parent dyadic psychotherapy who were not in parental custody at the beginning of the project. The court database of abuse and neglect filings at the time of the post-assessment were used to substantiate these findings. The therapists' reports were also used as another indicator at the time they closed their case. Third, the health and developmental status of children improved. Following treatment, 50% of the children who were screened ($n=22$) showed improvement in their developmental functioning as determined by the ASQ. Fourth, the percentage of caregivers reporting depressive symptoms, as determined by the BDI-II, decreased from 53% pre-treatment to 32% following completion of treatment, with 68% of caregivers reporting minimal to no depression after treatment at the time of the post-assessment. Finally, parent-child relationship functioning based on both observational assessments and parent reports improved significantly for both parents and children.

Parent-Child Relationship Functioning

To examine the treatment effectiveness, the pre- and post-scores on the Parent-Child Relationship Scales were analyzed. For some subjects, complete data were not available on all segments of the procedure; in those instances, the available segments were scored and analyzed.

Data were first analyzed for basal or ceiling effects, and scales were removed from analysis if more than 75% of the participants scored at the highest or lowest data points. Thus, child aggression was removed from the analysis as 83% of children were observed to display no aggression toward the caregiver. To facilitate data analysis, composite scales were created. First, identical scales from the free play and the clean up/structured tasks sessions were

averaged for each of the scales. Scales were further combined if they correlated at $r \geq .80$. As child positive affect and enthusiasm were highly correlated ($r = .85$), the two variables were combined to create a single child positive affect variable.

Paired *t*-test analyses were used to compare pre- and post-treatment scores. A total of 50 pre- and post-parent-child videotaped relationship assessments were available for analysis. Forty-six were used in the actual analyses since interactions were not included if the dyads attended fewer than three treatment sessions; in this sample, two dyads attended two sessions prior to the post-assessment.

Following the intervention, caregivers showed increases in behavioral responsiveness, emotional responsiveness, and positive discipline. Caregivers also demonstrated a decrease in intrusiveness with their children. Thus, compared to pre-assessment, post-treatment interactions were characterized by increased caregiver sensitivity. Children showed significant increases in positive affect following treatment. Caregivers showed increased responsiveness toward their children during the reunion after a brief separation, and, although it was not statistically significant, there was a trend for children to be more responsive to their parents during the reunion period. See Table 4.

Child Developmental Status

Prior to the intervention and using the ASQ, 32% ($n = 25$) had been screened as at risk for a developmental delay in one or more of the domains measured: communication, gross motor, fine motor, problem solving, and personal-social development. Following treatment and based on the ASQ, developmental status had improved in one or more areas for 50% of the children screened ($n = 22$). Forty-five percent ($n = 20$) improved in the communication domain, 17% ($n = 18$) improved in the gross motor domain, 17% ($n = 18$) improved in the fine motor domain, 28% ($n = 18$) improved in the problem solving domain, and 26% ($n = 19$) improved in the personal-social domain.

Parental Stress

Based on scores from the Parenting Stress Inventory, Short Form (PSI), 58% of caregivers responded as indicating little or no stress. These low reports of parental stress were found despite the fact that the parent was referred by the court or the child was placed in protective custody. Given the extraordinary number of tasks on the case plans facing mothers in the study, and the connection with the court's expectations for success in order for permanency/reunification to occur within 12–18 months, it was expected that the participants would have scored in the higher range of stress on the pre-assessment. These low scores, hypothetically, may suggest that pre-treatment, the full responsibility of being a parent of a young child, and what it will take to “get it all done” may not yet be clear to the participants. However, at post-treatment, the knowledge gained about the role of the parent in the relationship may be clear, and with that, comes increased stress to live up to all the responsibilities. Similar results have been found in our nonclinical parenting classes (Sheinberg, Goncz, & Katz, 2006).

TABLE 5. *Caregiver Satisfaction Survey Results*

Question Asked	Number of Participants Responding	% Answering Yes
Do you think that your relationship with your baby has improved as a result of treatment?	24	96
Has your child changed positively since the beginning of treatment?	26	92
Has your child's emotions changed since treatment began?	25	72
Has your child's behavior changed?	25	80
Has your parenting changed since the beginning of treatment?	26	81
Has your family life changed as a result of your involvement in this pilot study?	25	76
Have you learned anything new from being in this program?	27	96
Has treatment helped with the problems you and your child were having?	23	87

Caregiver Depression

Caregivers were administered the Beck Depression Inventory (BDI-II) prior to and following treatment. The BDI-II is a measure of depressive symptomatology that classifies individuals as having minimal, mild, moderate, or severe depression according to their self-report answers. The pre- and post-assessment data on the BDI-II was available for 34 caregivers. A paired *t*-test analysis was used to compare pre- and post-treatment BDI-II scores. The analysis revealed that caregivers were significantly less depressed following treatment [$t(33) = 2.441, p < .05$]. Prior to treatment, the mean BDI score of 14.85 (SD=10.03) fell within the mild range. Following treatment, the mean BDI score dropped to 10.88 (SD=12.18) and fell within the minimal range as determined by standardized cutoff scores.

Caregivers' and Therapists' Qualitative Impressions of Treatment

Following treatment, caregivers were asked a number of questions in order to provide a qualitative assessment of the caregiver's experiences of the treatment and its effects. Forty-four percent of participants who completed treatment also completed the satisfaction survey. One participant who was noncompliant with treatment and one participant who was currently in treatment also completed the survey. Given the low response rate, statistical analyses were conducted on demographic variables to determine if such factors were related to survey completion rate. Demographic variables such as caregiver age, caregiver race, caregiver relationship status, caregiver education level, caregiver employment, caregiver depression, and if the caregiver was ever incarcerated were not related to completion of the survey. Site of enrollment into the program was significantly related to completion of form. Seventy-two

percent of dyads in Pensacola completed the survey, 58% of the dyads in Sarasota completed the survey, and 28% of the dyads in Miami completed the survey. The questions and responses are listed in Table 5.

Therapists were also asked to describe their experience of treatment and its impact on the families served. Therapists noted positive outcomes of treatment beyond the primary goal of improving caregiver-child interactions. Other observed benefits of treatment included early detection of possible developmental delays in the identified child and his or her siblings, ability to follow through with the primary medical needs of the children, parents advocating on their children's behalf, and mothers recognizing the need for and establishing support systems.

DISCUSSION AND IMPLICATIONS

A major goal of the Infant and Young Child Mental Health Pilot Program in Florida has been to interrupt the intergenerational cycle of violence and to develop more effective and comprehensive evaluation and treatment programs for the most vulnerable young children and their families. The results of this program—which included relationship-based assessments, child-parent relationship-based psychotherapy, parental psychoeducation and guidance, and enhanced case management—indicated that parent-child relationship functioning improved significantly in all domains for both parents and children. Parents showed an increase in behavioral/emotional responsiveness and positive discipline with their children and a decrease in intrusive behaviors. Increased responsiveness and positive discipline and less intrusiveness from parents or caregivers is likely to enhance the child's development, positive self-esteem, and readiness to learn. Children showed an increase in positive affect in play with their parents. Both children and parents showed increased responsiveness to each other during the reunion after a brief separation. These results indicate more sensitivity, responsivity, and reciprocity in the parent-child relationship from the pre- to the post-test assessments. The increased responsiveness that resulted in both children and parents is important because early relationships form the basis for later relationships. If they are positive, development is likely to proceed more smoothly for children, as they are more likely to learn to relate positively to others such as teachers and peers. These findings also indicate that early intensive therapeutic interventions with these young, vulnerable children and their parents, combined with effective engagement and enhanced case management, can have a significant impact on both their development and their relationships that will lead to more positive self-esteem and increased readiness for school. There is also strong evidence that children who are abused and neglected without intervention are at higher risk for school failure and later violence (Widom & Maxfield, 2001). It is important to recognize and note that the data indicated completion of treatment was more likely for families with mothers who had completed high school, who may have been more highly motivated. These findings are consistent with the literature indicating that mothers with less than 12 years of education have children at highest risk.

Barriers and Lessons Learned

Efforts to engage families in the treatment process were critical. It was estimated that at least 10 hours of "engagement" efforts was spent for every hour of treatment. The engagement efforts included frequent telephone calls, home visits, child care visits, and other efforts to

build a trusting relationship with the parent. The efforts that were most successful were those that engaged the parents effectively to understand and recognize that they were very important for their infants and those that also allowed for a trusting relationship leading to confidence in the therapeutic relationship. Despite these efforts at engagement, a little over half of the sample did not complete treatment. Cooperation, collaboration, and communication with foster care workers was essential both to retain parents and children in the program and help with engagement activities. Collateral services were needed, which is often the case with high-risk families. A major barrier to the success of the program was problems with transportation. One site included home visits but even then, multiple attempts were made to find the families at home, even with prior appointments made for specific times. Further, the host agency had to be committed to providing infant mental health services. Indeed, the host agency had to absorb some of the costs of training and start up, as well as ongoing costs not covered by reimbursement.

Limitations

The Infant and Young Child Mental Health Pilot Program in Florida demonstrated that intensive evaluation and relationship-based treatment can impact positively on the interactions between very high-risk parents and children and their developing relationship. However, these findings, while significant, have several major limitations. First, the sample size completing pre- and post-assessments was small so that the generalizability of the findings is somewhat limited.

Second, this very high-risk sample had a high noncompliance rate, despite extensive efforts to engage families in the treatment and some being court-ordered. Of the 129 dyads referred during the 3-year treatment window, slightly less than half (57 dyads) completed treatment and post-assessment data. Thus, it could be construed that only the motivated families completed the intervention. While this may be the case, with families at such high risk, engaging almost 50% of them can be considered a major success.

Third, there was no control group to compare how the parent-child dyads would be doing without the intensive intervention or with another type of intervention. It should be noted, however, that in evaluating the effectiveness of therapy, results from randomized control trials may not translate well to naturalistic clinic settings and designs have been suggested that may mirror the naturalistic context in which the therapy occurs (Cohen et al., 1999).

Progress, Accomplishments, and Future Plans

Ongoing training at the pilot sites and other venues in Florida has resulted in the creation of a cadre of mental health providers with expertise in infant mental health. The pilot projects have increased awareness of the need for services and has served as a stimulus for more training in this area in Florida. All three pilot sites have succeeded in establishing their programs and integrating them successfully in their host agencies with commitments to sustaining the project beyond the pilot.

Following the Florida Infant and Young Child Mental Health Pilot Project, the Miami site has continued this model of infant mental health assessments and treatment for dependent children, by obtaining additional funding for ongoing collaboration between Judge Cindy Lederman, Administrative Judge of the Eleventh Circuit Juvenile Court and the University of

Miami's Linda Ray Intervention Center, with funding from the Department of Children and Families, District XI Division of Children's Mental Health, the Office of Juvenile Justice and Delinquency Prevention for a Miami Safe Start Promising Approaches site, and the Head Start Bureau for the Early Head Start Child Welfare Initiative (Katz & Osofsky, 2005). Remarkably, the intervention model developed and implemented by this Miami Court Team collaborative in the Eleventh Circuit Juvenile Court is being replicated and expanded in several jurisdictions around the country. Current work also includes: 1) a follow-up study of the Miami sample, funded by Zero to Three, to determine if the very positive results continue; and 2) continued work, in collaboration with Zero to Three and the National Council of Juvenile and Family Court Judges, to develop national models for juvenile dependency courts for abused and neglected children. These models include evaluation and services to determine the effectiveness of such interventions in other jurisdictions with the goal of breaking the intergenerational cycle of child maltreatment.

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CREATING PARENTING REFORM IN OUR DEPENDENCY COURTS

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One of the most fundamental tasks of a dependency court is to promote and ensure the capacity to parent in parents who have abused and neglected their children. This basic task is not a simple one, but requires evidence-based practice, pre- and post-testing, and observations of the parents with the child by a trained individual. Parenting programs can no longer be didactic classes where attendance is the only measurement of success.

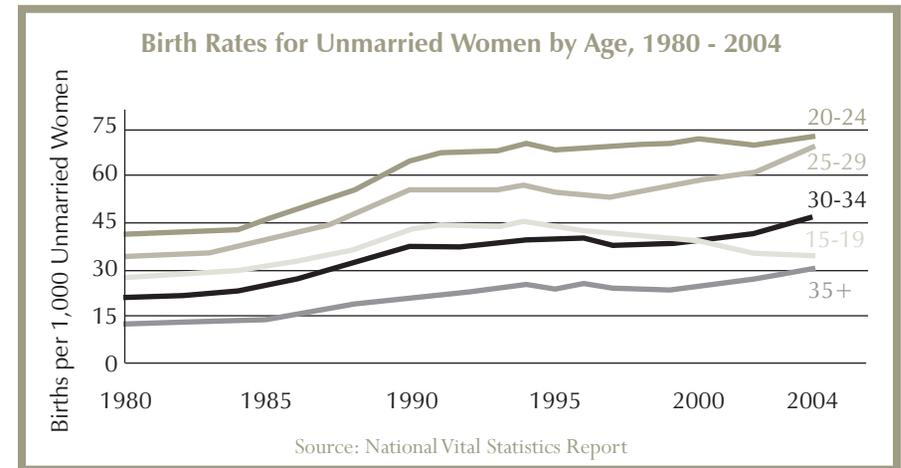
“I have my certificate of completion from my parenting course and I want my children back!”

Every day, judges in dependency courts across America remove children from parents who have failed their children. Mental illness, substance abuse, and domestic violence are common problems in these impoverished families, but the omnipresent problem is the inability to provide a safe, stable, loving, and nurturing home for their children. Parenting comes naturally—but it comes naturally based on our own experiences. What if those experiences are maladaptive? How do we expect a young mom who never felt safe and nurtured as a child to know how to parent her child in a caring, healthy way? The parents who come into the child-welfare system have learned parenting by assimilating the beliefs and practices of their family of origin, and, for many of them, parenting is little more than feeding and clothing a child. The level of parental functioning is often so deficient that we have to teach young parents to pick their baby up when their baby cries (dispelling their belief that it is not spoiling the baby), to smile at their baby, to play with their baby, and to not shake their baby when they become frustrated, angry, and tired.

Across this country, we have generally failed our families by using inadequate, non-evidence-based parenting services. Traditionally, we have sent these parents,

in groups, to didactic “parenting classes.” In most jurisdictions, there was no structured curriculum based on research; little monitoring and training; and no interactive component for the parent to practice with her child, in the presence of the parenting teacher, new skills to exhibit new levels of understanding. There are also no structured requirements to measure successful completion other than attendance. There are no systematic assessments of progress. There are *no* observations of parent and child interactions. There are no qualitative and quantitative measures to determine if insight has been gained and new practices and beliefs integrated. Successful completion was measured only by attendance, not by learning, understanding, or changing behavior.

It became clear to us that what we were doing in terms of “teaching parenting” was not helping our children and families and that the “commodity” we were ordering—parenting skills—was elusive and unable to be quantified. Reliance on didactic methods of teaching for parents, who had difficulty learning in schools using similar approaches, coupled with eclectic curricula with no accurate measures of parent progress for the most part, left judges standing in “quicksand” when determining whether the case-plan requirement for successful completion of parenting classes had been met. In addition, the provider network funded to deliver parenting classes lacked common curricula or ways to measure progress.



System-wide improvement was necessary. The frustrated juvenile-court judges announced that the existing programs would no longer be accepted as evidence of anything more than attendance. As a result of the judicial ultimatum, in cooperation with the community-based system of care-oversight agencies, parenting experts from academia and the provider network worked together to assist providers in selecting their curricula from the list of *Model Programs* (Substance Abuse and Mental Health Services Administration and Office of Juvenile Justice and Delinquency Prevention). Once each agency identified a curriculum that met the needs of their target population and was reasonably affordable for curriculum training and materials for start-up, the provider worked to obtain training in the program model. Each provider then applied to be a certified parenting provider.

Concurrently, the dependency-court work group determined that a system for data collection and pre- and post-client participation and progress needed to be developed. Quantitative assessments include, for example, the Adult-Adolescent Parenting Inventory-2 (AAPI-2) to track client progress. However, we also believed that evidence-based observational assessments evaluating changes in behaviors and emotions were needed to evaluate the effectiveness of parenting interventions for those who have abused or neglected their children—often repeating their own early childhood experiences. In collaboration with mental-health professionals, we have adapted a Parent-Child Observational Rating Scale to evaluate the effectiveness of the parenting intervention and outcomes for the parents and young children. The behavioral observations of outcomes include mutual positive engagement in the relationship; the caregiver’s awareness of the child’s developmental needs; caregiver rejection; child negativity toward the caregiver; caregiver teaching and helpfulness; the caregiver’s sensitivity and responsiveness to the child’s behavioral and emotional needs; and the child’s responsiveness behaviorally and emotionally to the caregiver. The behavioral observations are then incorporated in the parenting reports for judges so that the court can use this additional information about parenting interventions and changes in behaviors and emotions when making decisions about placement, visitation, and permanency for young children.

For the first time, a parent can actually attend all parenting sessions and still fail if the test scores and observations do not indicate that the parent has developed the capacity to parent without risk of harm to the child. The judge has a very detailed

report, the pre- and post-test scores, and the written behavioral observations at the judicial review hearings. Finally, an accurate determination can be made if the parent has benefited from the classes, what the parent’s strengths and weaknesses are, and what other services may be needed to enhance lower-than-acceptable parenting skills. The courts have a legal and moral obligation to make reasonable efforts to reunify families and improve the skills of parents. Anything less places vulnerable children in jeopardy.